DOCUMENT RESUME

ED 391 911 CE 070 773

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TITLE Perceptions of Needs among Individuals with Childhood Sexual Abuse History in Adult Education and Learning Support Settings.
PUB DATE Jul 95
NOTE 91p.; Master's Field Project, Western Washington University.
PUB TYPE Dissertations/Theses - Practicum Papers (043)

EDRS PRICE MF01/PC04 Plus Postage.
DESCRIPTORS Administrator Attitudes; Adult Basic Education; *Adult Literacy; Adult Programs; *Adult Students; *Child Abuse; *Literacy Education; *Needs; *Sexual Abuse; Teacher Attitudes

ABSTRACT

Childhood sexual abuse research demonstrates that a broad range of social and behavioral deficits may follow the victim into adulthood. Professionals in many service domains, including those in adult learning settings, encounter these deficits in their service populations, often without the benefit of educational background or resources to understand the barriers against which affected adults may struggle. A field project was designed to gather baseline information concerning how professionals in adult education settings respond to learners with histories of childhood sexual abuse. Through a survey questionnaire method, a representative sample of 108 adult educators and learning support personnel were asked about screening for childhood sexual abuse history, the presence of onsite services for individuals with this background, and the adult competencies perceived to be important for these adults to achieve. The project revealed that screening for childhood sexual abuse history varied considerably according to the type of adult learning support settings surveyed. The services provided also were different, depending upon the educational setting. Respondents, however, were consistent in identifying adult competency or achievement needs among those with a history of childhood sexual abuse. The project findings also supported the notion that adults with long-term childhood sexual abuse effects may comprise a population with distinct learning needs. (Contains 91 references.) (Author/KC)

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ED 391 911

PERCEPTIONS OF NEEDS AMONG INDIVIDUALS WITH CHILDHOOD SEXUAL ABUSE HISTORY IN ADULT EDUCATION AND LEARNING SUPPORT SETTINGS

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A Field Project

Presented to

The Faculty of

Western Washington University

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In Partial Fulfillment

of the Requirements for the Degree

Master of Education

****

by

Karen E. Redfield

July 1995

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ABSTRACT

Childhood sexual abuse research demonstrates that a broad range of social and behavioral deficits may follow the victim into adulthood. Professionals in many service domains, including those in adult learning settings, encounter these deficits in their service populations, often without the benefit of educational background or resources to fully understand the barriers affected adults may struggle against. This field project was designed to gather baseline information concerning how professionals in adult education settings respond to learners with histories of childhood sexual abuse.

Through a survey questionnaire method, a representative sample of adult education and learning support settings were asked about screening for childhood sexual abuse history, the presence of on-site services for individuals with this background, and the adult competencies perceived to be important for these adults to achieve.

The project revealed that screening for childhood sexual abuse history varied considerably according to the type of adult learning support settings surveyed. The services provided also were different, depending upon the educational setting. Respondents, however, were consistent in identifying adult competency or achievement needs among those with a history of childhood sexual abuse. The project findings also support the notion that adults with long-term childhood sexual abuse effects may comprise a population with distinct learning support needs.

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CHAPTER ONE
Introduction

Overview and Project Rationale

The incidence of sexual molestation during childhood in American society is shocking. Studies show that at least one of every four children is molested sexually during childhood, and some estimates assert that as many as three of every five boys and girls experience sexual abuse. Childhood sexual abuse (CSA) is even more devastating because of the long-term effects the victim may be doomed to traverse. While not all who were sexually violated as children are incapacitated in one way or another as adults, scientists have established CSA to be a strong predictor of various adjustment problems over the lifetime.

Childhood sexual abuse, for example, is a precursor to a host of somatic and mental health disorders. Although some disorders appear in childhood and lag into adulthood, many disorders will not be diagnosed until adulthood, and these may worsen as time goes by. The most common CSA adult problems appear as a diminished sense of personal efficacy, relationship dysfunctions, authority conflicts, anxiety and depression, substance abuse, social isolation, sexuality disorders, and post-traumatic stress disorder. Cognitive distortion, a variation of self-devaluation that often leads to the victim's denigration of life's possibilities, is also observed among the long-term effects CSA victims may sustain.

It is ideal that CSA issues are addressed during one's childhood, yet not all who need it will receive intervention for effects believed to be caused by abuse events. Many adult victims will carry the coping style that worked in

childhood into dysfunctions that impede adult growth and maturation. They are then at risk to being caught up in a vicious cycle of entering and exiting various helping systems.

Traditionally and formally, mental health settings, and more recently criminal justice settings, are the most likely to employ interventionists concerned with behavioral dysfunction and/or adult deviance associated with a history of childhood sexual abuse. Although the study and intervention of CSA effects has long fallen in psychological terrain, the trend is for increasing legal and judicial participation. This is important to hasten compensation and healing for victims, to provide quick actions to reduce further perpetration, and to speed the delivery of justice.

In addition to these traditional agencies, however, adult learning settings are also demonstrating heightened awareness and concern for adults with a history of childhood sexual abuse. The occurrence of sexual abuse during childhood can cause learning participation to be more difficult an endeavor than it is for those who did not experience childhood sexual abuse. For example, many who dropped out of school due to issues rooted in child sexual violation will enroll in education or training requirements and actively seek intervention when achievement deficits have frustrated adult growth and economic progress. Yet, the emotional and cognitive barriers and coping mechanisms that impact participation and progress at younger ages may still be unresolved.

As a result, acceptance of traditional gender roles, for example, may cause the female victim to assume a passive stance toward personal enrichment and advancement through education. For economically disadvantaged victims, often there is acquisition and accommodation to a

culture of poverty which hinders directly and indirectly their motivation and access to learning situations. Many will procreate at too young an age, which often interrupts education and training program completion. They may drop out of school for a variety of reasons: chronic runaway, poor peer associations, substance abuse, and conflict with authority are some of the reasons school attendance is a problem. Other victims may have entered a lifestyle of deviance involving crime or prostitution. Some manage to fall victim to all of the above hindrances to learning endeavors. And yet, research has demonstrated that improving education levels among CSA adults helps their integration into socially endorsed strata, such as their ability to parent effectively, sustain gainful employment, and remain drug/crime free. Education also helps them stabilize their family and social relationships. In addition, being able to attribute meaning to abuse events is considered an important part of recovery.

It is of value, therefore, that learning endorsers develop and offer adjunctive assistance for those who bring with them a history of childhood sexual abuse. At a minimum, educators and learning advocates should be able to refer an affected adult to appropriate resources. Such would be particularly relevant for those who serve or encounter disadvantaged CSA affected adults, such as in entry level adult basic education programs, social service agencies, employment agencies, criminal justice programs, and other low-income programs. Furthermore, knowledge of CSA effects would help professionals better serve those who are under contingency or mandated to engage in activities that require them to learn. It is in such contexts that informed learning support professionals can help the adult victim to perceive their issues, identify specific achievement

barriers, and help them to access support for their efforts to escape the heavy grip of childhood sexual abuse effects.

Need for the Study

Current access to and availability of education approaches to address adverse CSA effects among adults, however, are obscure and ill-defined. Adult educators and learning support professionals are not acknowledged as CSA stakeholders. Furthermore, the nature and variety of learning and learning support settings where CSA issues are encountered by various professionals lacks documentation. There are educational system deficiencies and access problems, part of which are related to learner barriers, lower rates of education participation and incomplete schooling. One consequence is that adult educators and learning support professionals may fail to recognize their position to help CSA learners become more capable of learning in order that they might experience the kind of success that promotes commitment to life-long learning and achieving the ideal qualities of participatory, self-directed learners.

Society often nets victims due to their personal and social stumbling, such as for mandated substance abuse recovery program participation, custody contingency parenting classes, mandated job-training participation, education programs, and criminal justice programs. For those so netted, service professionals who are knowledgable about the signs and symptoms of CSA history would be better able to identify the behavioral indicators that predict participation problems.

The lack of curriculum about CSA adult symptomatology during a professional's education and training is a shortcoming of current

educational content. In fact, professionals who work with those affected by child sexual abuse primarily obtain background theory and information through peer networks and interests, conferences, journals, and inservices. Therefore, the extent to which many professionals align their observations with research findings speaks more to what they gain from field encounters, rather than what they learned through college and university curriculum.

Finally, the effects of childhood sexual abuse can confound the personal progress and program participation that affected adults engage. Service professionals often encounter adult victims as service needy individuals who move more slowly through programs as compared to unaffected adults. This slowed progress has implications for program designs and cost controls which allow for the pace at which affected adults proceed. If professionals lack knowledge about CSA effects, the result can be a lack of professional sensitivity that may actually deepen the barriers affected adults are already at risk to experience.

Study is needed to delineate the experiential base learning support professionals have with CSA affected learners, as well as the availability of services for CSA adults in diverse learning support settings. In addition, the scope and titles of such settings that offer services needs nominal identification as a help to targeting, strengthening, and supporting professional stakeholders and potential resources for CSA victims.

Project Focus

This project is an attempt to explore a baseline as to whether professionals in adult education and diverse adult learning support settings encounter affected adults and how they perceive adult achievement needs

among CSA victims. The project explored the scope of learning support settings where CSA history might be deliberately screened during intake procedures, and whether services could be accessed on-site. Also, the project activities were intended as a preliminary probe by which to frame consensus among diverse professionals as to whether CSA history can be said to predispose the affected adult to fall within a distinct learning needs population. The project explored whether CSA history can be positively associated with adult achievement and competency deficits.

In order to obtain this information, the following questions became the focus of study:

- Do learning settings and settings that offer learning support services (i.e., colleges and universities, human services agencies, substance abuse treatment facilities, counseling centers, and prison education sites) screen applicants for the presence of CSA history?
- Are special or distinct services offered on-site for adults with CSA history?
- When services are offered, what competencies and needs are perceived by professionals to be important for CSA affected adults to achieve or fulfill?
- If no on-site services are offered, what is the opinion of those who may have encountered CSA adults about achievement needs believed appropriate for many adults with childhood sexual abuse history?
- Do adults with childhood sexual abuse history comprise a distinct learning population?

Definition of Terms

There are variations in the parameters of what defines childhood sexual abuse for the purposes of research. Some studies considered childhood as the span of years spent as a legal minor. Others defined childhood as the period of time constituting ages 13 and younger; while some define it as 16 years and younger. Also, sexual abuse has various definitions. Some define CSA as unwanted sexual advances perpetrated by offenders at least five years older than the victim. Others qualify sexual abuse to acts that involve inappropriate touching within the "private" zone; and some restrict sexual abuse to digital or penile penetration of the genitals, mouth and anus. Other definitions include acts of peeping, child pornography, and using sexually explicit language with children to be forms of sexual abuse.

An exact definition of childhood sexual abuse was not critical to the project. However, the following definition was considered inclusive enough to embrace most people's understanding of the phenomenon:

> Childhood sexual abuse is any behavior perpetrated against a legal minor on an intimate level that trespass the cultural norms of any social unit. These behaviors are those usually reserved for consenting adults. Such acts may be covert in public settings, but are usually conducted in secrecy through complicity of affection, coercion, or threat. This includes any intimate conduct not acceptable in front of neutral observers, or in ways considered private or sacred. This definition includes victimization of children by older children and siblings.

In all cultures, and in all religious precepts, there is universal prohibition against incest (Roesler & Wind, 1994).

CHAPTER TWO

Review of the Literature and Related Research

Sexual Abuse Research: Historical Considerations

It is within the past two decades that research into the prevalence and negative effects of sexual abuse gained the impetus that today shows no sign of abating (James & MacKinnon, 1990; Sgroi, 1975). The feminist movement in the 1960's is said to have spearheaded scientific study and social awareness about rape (Sharma & Cheatham, 1986). According to Herman (1992), latter-day probing into the etiology of the socially disruptive and penetrating disorders of sexual trauma was initiated by women scientists. The women's movement is also credited with vocalizing the validation and recovery needs of rape victims such that mental health treatment approaches began to be developed for sexually assaulted women in the 1960's (Courtois, 1988; Groth & Birnbaum, 1979; Lew, 1990; McCann, Pearlman, Sakheim, & Abrahamson, 1988; Young, Bergandi, & Titus, 1994).

Investigation of the effects of sexual violation on children followed in the mid to late 1970's. Professionals now study in ever-narrowing focus the factors that contribute to specific outcomes for victims of sexual abuse. There are strong predictors that mental health disorders will occur in people who are sexually abused during childhood (Hanson, Lipovsky, & Saunders, 1994; Saunders, Kilpatrick, Lipovsky, Resnick, Best & Sturgis, 1991). An important research quest today is to identify factors that promote resilience toward normalcy. For most victims, it is believed that early intervention may spare them from some of the bleakest effects that CSA is associated with.

In regards research conducted among victims studied while they were

still children, Spaccarelli (1994) provides an excellent review of current research and theory for child-aged sexual abuse effects. Unfortunately, many victims are not attended for sexual abuse issues during childhood. The result is that many studies are retrospective in nature, using the memories and symptoms of adult victims to study CSA effects. Nonetheless, retrospective studies are valuable sources of data collection. For example, one theory supported by retrospective studies is that negative effects endure, (even becoming worse over time), and may be exacerbated as the individual enters crucial stages of normal developmental tasks (Briere & Runtz, 1993).

Demographics of Child Sexual Abuse

The age at which victims report their first encounters with sexual abuse is astonishingly young. The average age of first experience with sexual abuse is found to be between 9 to 11.2 years for boys and girls (Finklehor & Baron, 1986; Russell, 1983; Wurtele & Miller-Perrin, 1992; Wyatt, 1985). The average age of first encounter of child sexual molestation is eight years old in a Washington State study (Roper & Weeks, 1993) and nine and a half years old in a national study (Finkelhor, Hotaling, Lewis, & Smith, 1990).

As an indication of the high prevalence rates of childhood sexual abuse in selected populations, listed are various study findings between 1988 to 1993:

- 62% of teen parents who conceived before age 17 in Washington State reported sex-abuse (Boyer, Fine, Kilpatrick, & Liebert, 1992).

- One of four women on public assistance in Washington State report sexual abuse during their childhood ("Women in Transition," 1993).

- 1991 National female prison inmate statistics report one of three women in prison was sexually abused in childhood (Snell & Morton: U. S. Department of Justice, 1994).

- 46% of women in a random digit dialing in Los Angeles reported sexual abuse as children (Peters, 1988).

- 60% of female undergraduates reported sexual abuse in childhood [in a sample size 15% of 10,000 female university students in 1989], (Carlisle, 1992).

- In a study that measured women's CSA history in a variety of settings, it was found that 68% of women in an alcohol abuse treatment program affirmed childhood sexual abuse; 62% of battered women in a shelter; 63% of women in a mental health treatment program; 21% of the women arrested for DWI in the study; and 39% in the randomly selected study comparison sample reported childhood sexual abuse (Testa, Miller, Downs, & Panek, 1990).

- A study conducted with 52 female sex-offenders in a Seattle, Washington, offender program revealed that 65% were positive for a history of childhood sexual abuse (Wolfe, 1995).

Child sexual abuse was once believed to be primarily perpetrated against little girls by male offenders. This bias is reflected by the abundant studies conducted with female victims molested by males. The effects of CSA on males has come under increasing scrutiny lately with much of the data about male victims available since 1991 (Benoit & Kennedy, 1992; Hunter, 1991; Wolfe, 1995). Also, it was once believed that women could not be sex-offenders by nature of their mythically passive function in the sex act. The scarcity of studies

with women offenders is another example of research gender bias.

Presently, the questions once expected to be answered exclusively by one gender are increasingly asked of either gender. Nevertheless, the tendency is for men to be more silent on their history of sexual abuse than women. This is attributed to cultural perceptions and traditional-role gender socialization (Carlisle, 1992; Hunter, 1991; Lamb & Edgar-Smith, 1994; Summit, 1993). For male victims, establishing sexual identity has been found to be confusing (Freeman-Longo, 1986; Hunter 1991; James & MacKinnon, 1990; Johanek, 1988). And males, for example, may believe they are implicated as willing participants if they achieved an erection.

The male may be ashamed that they were able to become a victim, a response that males may regard as a feminine attribute. Scientists surmise that in American society it is a cultural norm to associate victimization with feminine attributes and traditional powerlessness. This is considered to be among the hindrances of timely intervention for boy victims, which could concurrently help to reduce additional offenses (Young, Bergandi, Titus, 1994). The silence of males urgently needs correction in light of findings that the average extrafamilial offender molests around 150 male victims as compared to 19.8 female victims by a single offender (Chaffin, 1994). (On average, incest offenders molest two victims).

Demographics of CSA Among the Disadvantaged

A culture of poverty often characterizes the economic and educational attainment of CSA affected adults ("Women in Transition," 1993). Alleviating the potential for poverty among CSA victims is made more difficult by CSA victims who elude timely intervention. This could be attributable to undisclosed

victimization during childhood, the increased tendency for victims to dropout of high school, and high teen pregnancy rates among CSA affected youth (Roper & Weeks, 1993). Poverty can affect the stabilizers that support participation in training and education programs.

A Washington State welfare reform study conducted from 1988 to 1992 among recipients of Aid to Families with Dependent Children (AFDC) analyzed the relationship of households headed by women on welfare to factors influencing length of stay on public assistance ("Women in Transition," 1993). The study explored the demographics of participation in training programs, education achievement levels, education enrollment, and abuse rates that study subjects reported (physical and sexual).

It was found that "almost half of the women on public assistance reported physical or sexual abuse while growing up" (p. 10). Rates of abuse for both the "at risk of being on welfare" comparison group and the sample populations were high. For those on welfare, the rate of physical and sexual abuse history was 59%, while 39% of the comparison population reported abuse during childhood.

A tandem study conducted by Washington State during the same time-frame linked child sexual violation with teen pregnancy and prolonged welfare dependency (Roper & Weeks 1993). Two-thirds of the welfare respondents, averaging 30 years old in 1988 at the start of the study, reported physical and sexual abuse during childhood.

Teen pregnancy was the common eligibility entry criteria for the majority of long-term welfare recipients surveyed. It was found that early sexual activity was highly correlated to sexual victimization history. In addition, many of those already on public assistance subsequently had repeat pregnancies before age

20, a factor that is associated with prolonged dependence on welfare. It is appalling that 91% of the women on assistance who had been sexually abused, and who elected to be sexually active before the age of 15, also became pregnant teenagers (Roper & Weeks, 1993, p. 7).

In discussing the study population's teen sexual activity, Webster and D'Allesandro (1991) reported that:

> 71% of the women on assistance who were sexually active at an early age dropped out of school; of those who dropped out, almost all (93%) became pregnant teenagers. Half (52 percent) of the women on assistance [in this study] were teenage mothers. (Cited in Roper & Weeks, 1993, p. 7)

As part of Washington State's welfare reform experiment, work or education cash incentives and childcare was made available to recipients during the time these study data were collected. Yet these cash incentives induced less than one-third of the "Women in Transition" (1993) sample population to enroll in education or training programs. For the one-third that accepted the program incentives, data revealed vocational education and training enrollment had an outcome of 76% employed by the end of the study, while there were 32% employed who completed post-secondary academic education. For the other two-thirds of the women eligible for job/education incentives, such appeared not to be a sufficient inducement to enroll in education or job-training programs. This finding closed the doors on further use of cash incentives in Washington State's welfare reform efforts.

If child abuse history predisposed many study subjects on public assistance to live aloof from the world of paid employment and educational

pursuits, the State's publications were silent. Furthermore, the study did not distinguish those who reported sexual and physical abuse while growing up from those who participated in work and education activities. Little was concluded about the association of child abuse history to decreased adult self-sufficiency behaviors. There was only a hint that this association might exist. To this date, no action plan has been devised to address the findings.

In arriving at or heading toward recalcitrant economic disadvantage there are strong indications of a childhood history of physical and/or sexual abuse. Such was also supported in an unrelated demographic report for Washington State Department of Social and Health Services, Child Protective Services (CPS) compiled on behalf of a non-profit independent teen emergency shelter operated in Everett, Washington (Redfield, 1993).

Demographic data was compiled for 149 teens sheltered between July, 1991 to December, 1992 from intake applications. The average age of teens entering the emergency shelter was 16 years old. The youths usually claimed they were expelled from the home by their parents. The sheltered teens were screened as free of criminal history and it was contraindicated that they be foster care recipients with CPS. 47% of the female population reported incidents of sex against their wishes in their past, and 9% of the male population reported sexual abuse history. However, there was reason to suspect underreporting, as staff reported that once the teen gained trust with the staff physical and/or sexual abuse was confided as a contributing cause of homelessness for nearly every applicant.

Furthermore, of these 149 teens, 75 dropped out of school. Sadly, there were insufficient community resources for many of them to achieve regular school attendance and shelter stability that would allow them to complete their

secondary education.

Sadly, negatively affected CSA youth often face participation in education against barriers like poverty, deprivation through isolation, low self-esteem, running away, homelessness, deliquence, and the high risk of having children before being emotionally and economically prepared to parent.

One study exploring the causes of teen pregnancy suggested that relief from the psychosexual disruptions of CSA for adolescents may take shape through the processes of reproduction (Boyer & Fine, 1992). In essence, the female's violated genitalia is theoretically purified by producing a blameless baby. Her emotional needs will be met by one who will rely on her for every need, someone she presumes will love her for herself. In an article related to the study it was stated that, "Reproduction appears to be a healing event to those broken by violation" (Boyer, Fine, Kilpatrick, & Liebert, 1992, p. 5).

This study cited high rates of abuse prevailed in the histories of 535 pregnant and parenting teens who participated. The sample excluded teens who had miscarried or terminated their pregnancies. It excluded school dropouts, requiring that participants be students who had conceived or delivered a child before the age of 17. While emphasizing the difficulty of finding a comparison group of girls that had not been abused, they reported that 62% of the sample population "had experienced molestation, attempted rape or rape prior to their first pregnancy" (p. 5). Boyer, Fine, Kilpatrick, & Liebert, (1992) wrote:

> What seemed to be a simple nurturing task of working with women and babies, a human service agenda that seemed solvable with technology, has taken on a new dimension. The

> real problem of teen pregnancy is not the problem many in the field wanted to work with [i.e., child abuse] . . . Given the sexual events in a long path of involuntary sexual activity, biology will prevail. Voluntary choices cannot expect to impinge in the long run of an involuntary course. (p. 5)

Poverty compounds the risk for CSA victims to be revictimized by reducing access the victim has to safe environments and helping resources. There is diminished movement toward self-sufficiency associated with the long-term effects of sexual victimization. Some may choose and some are forced to be homeless because of victimization.

For girls, pregnancy opens the world of adult choices much earlier than educational status, earning power, and social awareness skills normally dictate. Yet another category of the economically disadvantaged occurs among the criminal population. In a study by Wolfe (1995) with 52 female sex-crime offenders participating in an offender program operated in Seattle, Washington, only one in four was considered economically self-sufficient.

Child Sexual Abuse Empirical Symptomatology

The present day finds researchers facing a sea of variables that mediate to impact the outcome and process of recovery for victims. Coping and adjustment to the effects of sexual abuse is thought to be related to variables in personality, whether disclosure was attempted as a child or not, the nature of family dynamics and supports, the relationship of the perpetrator to the child, duration of abuse events, and community response when there is disclosure (Briere & Elliot, 1993; Cole & Putnam, 1992; Herman, 1992; Nash, Hulsey, Sexton, Harralson, & Lambert, 1993).

In addition to external variables affecting outcome, studies have shown that child sexual abuse negatively affects human development and cognitive perceptions. Downs (1993) explained that the "increasingly negative effect [over time] is hypothesized to be a function of developmental needs being bypassed or short-circuited as victims pass through later stages of development" (p. 333). For some victims, symptoms that were quiescent in childhood may exacerbate during adolescence and adulthood as responses and contexts around abuse events clarify during the individual's cognitive, sexual, and social development (Alexander, 1992; Finklehor & Browne, 1986; Cole & Putnam, 1992).

Because CSA negative effects often appear in combinations (labeled with terms like sequelae and syndrome), these are often empirically referred to with the term, CSA sympotomatology: that is, the study of the clusters of effects linked to childhood sexual abuse, both immediate and long-term. CSA symptomatology (also, occasionally called victimology), are effects that involves some or all of the following in varying degrees:

- Traumatic sexualization–which leads to sexuality disorders, sexual precociousness, and a greater incidence to engage in prostitution; betrayal, stigmatization, and powerlessness was identified by Finklehor (1987). The victim may act highly sexualized but finds engaging in sex unsatisfying and distasteful (Downs, 1993; Finkelhor & Browne, 1986; Maltz & Holman, 1987).

- The victim may experience "depression, behavioral and social problems, (e.g., prostitution, alcoholism, substance abuse), emotional disorders, suicide, somatic disorders, low self-esteem, problems in interpersonal relationships, sexual disturbances, and revictimization" (Finklehor & Browne, 1986; Gelinas, 1983; cited in

Downs, 1993, p. 331-332). The predisposition to being revictimized is believed caused by being less able to distinguish between safe and unsafe situations (Davis, 1991, Downs, 1993, Herman, 1992).

- Complex post-traumatic stress disorder, presented in J. Herman's (1992) revised version of post-traumatic stress disorder [DSM III-3, 1980], is frequently diagnosed in CSA adults. (See Appendix A for a thorough listing of the negative effects under this diagnosis).

- Cognitive distortions may occur, involving feelings of guilt and responsibility for having been sexually abused. The victim may believe they are inherently "bad" and undeserving of a good life. The victim self-denigrates their potential for success and happiness. It is a coping mechanism which victims manifest in consequence of not be able to find a rational meaning for abuse events (Briere & Runtz, 1993; Burt & Katz, 1987; Jehu, 1989).

- Progressive accumulation is a developmental task pileup Downs and Doueck (1991) identified. This theory explains that the effects of CSA often appear delayed and it accounts for behaviors that seem to worsen over time long after abuse events have ceased to occur.

While the above problems were findings in studies that used female subjects, studies comparing gender align the findings for male victims closely with effects observed in females, with the exception that rage and aggression are common behaviors men attribute to themselves while women report they are more submissive and suffer depression (Frazier, 1993; Lamb & Edgar-Smith, 1994; Young, Bergandi, & Titus, 1994).

In a landmark study, the child sexual abuse accommodation syndrome was identified by Summit (1983) as a "common denominator of the most

frequently observed victim behaviors" (p. 180). The syndrome comprises "secrecy; helplessness; entrapment and accommodation; delayed, conflicted, and unconvincing disclosure; and retraction" (p. 181). Under conditions in which sexual abuse is sustained over time, in order to survive and cope, children may adopt what Summit (1983) labeled the "accommodation syndrome." For the syndrome to apply, the offender would have steady access to the child by the nature of their status or closeness with other family members. To procure the victim's secrecy and cooperation, the perpetrator may threaten the child or the child's family integrity, while lying and deception may be used to groom compliance.

Summit (1993) explains that the cognitive function of the victim's successful accommodation to abuse is to allow the child to rationally maintain the secrecy demanded by the perpetrator; thereby reducing the victim's distress to conflicting internal values. This ability to accommodate to sexual molestation forestalls the "splitting of conventional moral values" (Summit, 1983, p. 185). This is a child's attempt to restructure reality to make sense of incongruent social messages. Unfortunately, Summit (1983) explains, "The same mechanisms which allow psychic survival for the child become handicaps to effective psychological integration as an adult" (p. 185).

Summit's (1993) explanations laid the groundwork for intervention rationales that require the professional to address the victim's cognitive processes. Furthermore, this theory helps in understanding the cognitive dynamics underlying behaviors that seem changed and bizarre. His theory established a basis for future research that would associate the purpose of cognitive distortions to the victim's search for the meaning of sexual abuse events. But understanding cognitive distortions associated with sexual

violation in childhood is made clearer when it is understood how difficult it can be to disclose that sexual abuse is occurring, or has been a secret the victim kept for a long time.

CSA Disclosure Problems

There are problems diagnosing the cause of behaviors in one who has not disclosed that sexual abuse has occurred. Knowing the cause of a problem is an important part of treating the problem. Appropriate identification and interventions can be difficult if negative behaviors that began as coping responses to sexual abuse become obscured by the passage of years (Spaccarelli, 1994).

Intervention to mediate long-term effects is further hampered by underreporting and undetected incidences of childhood sexual violation (Abel, Becker, Mittelman, Cunningham-Rathner, Rouleau, & Murphy, 1987; Abel, Becker, Cunningham-Rathner, Mittelman, Rouleau, 1988; Chaffin, 1994; Lawson & Chaffin, 1992; Wurtele & Miller-Perrin, 1992). For a child, disclosure can be perceived as so uncomfortable and threatening that it is not uncommon for the victim to delay seeking help until adolescence and adulthood.

Most interventionists recommend timely disclosure of sexual abuse. Disclosure for a child is important to help the abuse to stop and is considered an important aspect of intervention. However, there is controversy about the effectiveness and consequences of disclosure, and many studies have been conducted to explore the perceived benefits and dangers of disclosure.

When disclosures are offered by adults, because the response is unpredictable, courage and trust are reciprocals between the adult and the listener for sexual abuse history to be shared. In the absence of anonymity,

mention of sexual abuse history can seem risky, dangerous, inappropriate, or irrelevant; even if it could help to explain behaviors that otherwise seem strange.

In addition, disclosure is not always welcomed by the hearer, because the listener may learn that the offender was a family member, a close friend, or a significant other who is accused. The degree of belief and support offered by the hearer is considered an important mediating variable towards recovery, especially when it is a child confiding with a parent (Friedrick, Luecke, Beilke, & Place, 1992; Sorenson & Snow, 1991).

Delayed disclosure may be a risk to the victim's credibility, for to disclose sexual abuse long after abuse events have ended can seem out of context and unconvincing to those that first hear of it (Summit 1983). As a result, retracting their claim is common and should be anticipated (Summit, 1993). There is also the risk that the victim may be disbelieved when physical evidence is lacking. In addition, disclosure credibility may be compromised by the caregivers' experiences with a victim who has a history of acting out, tantrums, violence, or delinquent behaviors (O'Connell, Leberg, & Donaldson, 1990). Disclosure impediments have implications for the pursuit of justice with offenders and the nature of supports the victim will need for compensation and healing.

Trepidation about the abusers' threats being carried out can confound the need to disclose. The victim might believe the perpetrator's threats that love will be withdrawn; or competence, relatedness, and autonomy are threatened if they do not comply with the offender's demands (Skinner & Wellborn, 1994). The victim might also fear or perceive danger to family members or friends if threats are used to coerce sexual complicity (Johnson &

Kenkel, 1991). It is true that the victim's safety and status may be at risk because of events following disclosure (Lamb, & Edgar-Smith, 1994). Also, the family unit may be broken apart when the crime is one of incest (Roesler & Wind, 1994; Summit, 1983). Furthermore, disclosure of sexual abuse may agitate feelings of guilt, complicity, and shame if physical arousal was experienced, which is common (Abel, Becker, Mittelman, Cunningham-Rathner, Rouleau, & Murphy, 1987; Downs, 1993; Finkelhor, 1987).

Some studies have found that the younger the child was at the time of disclosure, the less supportive the response is interpreted to be by the adult (Roesler & Wind, 1994; Lamb & Edgar-Smith, 1994). In comparison, victims who were at an older age at the time of disclosure reported that the perceived level of support from the listener was greater. Roesler and Wind (1994) found that those who disclosed for the first time at adult age were more likely to be better educated, but in addition, were more likely to have repressed their memory of abuse during childhood.

Although impediments to disclosure often prolong the recovery process, studies can show that some victims regarded delayed disclosure to be helpful and their perception of support was greater than those who disclosed at younger ages. However, some studies have demonstrated that for some who delayed disclosure of sexual abuse in childhood there was self-blame for failing to make the abuse stop sooner. This was attributed to worsening their feelings of guilt, depression, and neurotic anxiety (Morrow, 1991; Wolfe, Gentile, & Wolfe, 1989; Wyatt & Newcomb, 1990).

To reduce disclosure rejection risk, to improve timely disclosures, and to increase listener reception and sensitivity to disclosures of childhood sexual abuse, it is suggested that adults be educated about appropriate responses in

order to promote prevention efforts. It is also suggested that adults be taught to identify behavioral indicators of sexual abuse in children and adolescents. This prepares them to be more sensitive and supportive of disclosures (Lamb & Edgar-Smith, 1994; Lawson & Chaffin, 1992).

In summary, it appears that the benefits and detriments of disclosure aspects present a bewildering dichotomy.

The Search for Meaning and Cognitive Distortions

In support of those who use their intellect to avoid the trauma disclosures can initiate, Lamb and Edgar-Smith (1994) introduced that an astute victim may intuit when disclosure is believed safe and likely to be supported by the listener. Likewise, intelligence may serve to help a victim, otherwise trapped by disclosure ambivalence, to avoid the risk of receiving a negative response. For example, intelligence enhances one's ability to find meaning to sexual abuse events independently.

The search for meaning of distressful events is considered a primary human motivation by Frankl (1963). In this context, Silver, Boon, and Stones (1983) "found that adult survivors of incest who were able to make sense of their abuse were less distressed psychologically, were better adjusted socially, showed higher levels of self-esteem, and had greater resolution of their experience" (cited in Lamb & Edgar-Smith, 1994, p. 309).

CSA researchers define cognitive distortions in terms of altered self-concept (Finkelhor, 1987; Spaccarelli, 1994). Briere and Runtz (1993) write that cognitive distortion is based on the premise that:

> People make significant assumptions about themselves, others, the environment, and the future based on childhood

> learning. Because the experiences of former child abuse victims are, by definition, usually negative, these assumptions and self-perceptions typically reflect an overestimation of the amount of danger or adversity in the world and an underestimation of the abuse survivor's self-efficacy and self-worth. (p. 314)

A person who is unable to make the perpetrator stop abusing them may develop the impression that the world is dominated by those who perform deeds against them despite their resistance or discomfort. This notion also rests at the heart of learned helplessness (Summit, 1983). Cognitive distortion may cause victims to doubt their ability to experience success in a self-advancing activity, such as education or training.

Other hindrances to the quest for meaning can especially impede the recovery of female victims. An external locus of control is associated with traditional female socialized gender-role behavior among adult victims of molestation in the findings of Carlisle (1992). This research found that females sexually abused as children tended to adopt "socialized traditional passive/powerless female gender-role behaviors as adult women" (p. 10). Gold (1986) found that:

> Women with a history of child sexual abuse were more likely to attribute negative events to internal, stable, and global factors, as well as to their character and to their behavior. These same women tended to attribute the cause of good events to external factors. (Cited in Briere & Runtz, 1993, p. 315)

Difficulty finding meaning for abuse events and cognitive distortion has implications for the teachability of an individual. Afterall, sustaining high

enough grades, juggling relationships, and maintaining the day to day struggle of student-life can be great stressors on even the most well-adjusted of students. For CSA affected females, an external locus of control with low self-efficacy, combined with inarticulated, but strong, identification with traditional-gender female roles increases the risk of readily exhausted volition towards education and training participation.

For those who fail to find meaning to abuse events without intervention by families, schools, and communities, a propensity towards mental illness and/or involvement in criminal acts often works against their desire for healing and personal growth. This is one reason that mental health and criminal justice providers are the typical interventionists for those who succumb to negative CSA affects (Kelly, 1990; Kilpatrick & Otto, 1987; Young, Bergandi & Titus, 1994).

Implications for Adult Education

Guidance, information, and encouragement cannot be limited to mental health and criminal justice providers. In fact, CSA adults who qualify as resilient, that is, they have resisted the predictors of negative outcome, have unique insights into how guidance and education can help those still suffering from or ignorant about long-term CSA effects. Recovering victims (called survivors) are powerful advocates for change and awareness. They vocalize recovery needs, sponsor support groups, and challenge policy and social myths. They are largely responsible for the great surge in self-help books now available. Such can be the fruit of bringing meaning to abuse events; some can sublimate childhood trauma into benevolent lessons for the good of all.

Adult education is implicated as an important interest in CSA outcome by its role in community services and teacher education curriculum. For instance, the effects of childhood sexual abuse in the victim spills into neighborhoods and communities, while the presence of sexual abuse indicates offenses need to be managed. Although victim behaviors may forebode public-system dependence or criminal acts certain risk factors can be identified if the victim is screened during adolescence with a label such as "youth-at-risk." Conversely, there are tactics that communities can use to help the vulnerable avoid violation. In this regard, educators are increasingly being mobilized to unite in school-based programs the kind of community organization that facilitates the development of resilience. Schools and communities organized to mediate positively, in spite of the presence of at-risk indicators, help reduce the negative outcomes of risk factors by facilitating resilience to adversity (WRC, 1991).

In addition, improving the education level among victims has been shown to be particularly effective in helping adults cope with their CSA histories. It is therefore important for adult educators to be knowledgable about general CSA symptomatology. Adult educators are concerned with learning barriers and the role of learner content for enacting individual and social change (Brookfield, 1986; Brookfield, 1987; Merriam & Caffarella, 1991). They are important members in any social intervention strategy (Cunningham, 1988, Lindeman, 1961). Being able to recognize symptomatology would allow the educator to make informed assumptions about the supports, validation, and learning needs of developing individuals in their service populations.

In particular, cognitive distortion and interrupted developmental task

completion brought about by childhood sexual abuse has significance for the readiness of learners to participate in classroom learning activities. For example, Belenky, Clinchy, Goldberger, & Tarule (1986) posit five categories of women's perspectives on knowing ranging from a position of "silence" to one of "constructed knowledge."

- Silence, at which stage the female learner is "mindless and voiceless; subject to the whims of external authority," is defined as a position of feeling incompetent; as if defined by others and as passive.

- Received knowledge is a stage in which self concept allows the female to receive and reproduce knowledge from external authority, "But, their world is literal and concrete, good or bad."

- Subjective knowledge is a stage at which "women begin to gain a voice" through valuing intuition with the "locus of truth [shifting] to the self."

- Procedural knowledge takes two forms: separate knowing which allows her to question and reason about the objects of discourse; and connected knowing, where "there is intimacy and equality between the self and the object of discourse, based on empathetic understanding."

- Constructed knowledge is the stage at which knowing is contextual. The female experiences herself as a creator of knowledge; valuing "both subjective and objective strategies for learning. This stage is characterized by the development of an authentic voice." (Cited in Merriam and Caffarella, 1991, pp. 192-193)

In working with CSA adults on issues of cognitive distortion, the model above would assist the professional by providing a framework that identifies the learners' participation capability along this range of knowing. One can foresee that the adult is more likely to be retained in an introductory level program when she can adopt the level of knowing at stage 2. Each successive stage has implications for the educator to use in determining what can be expected of participation, content delivery tactics, and perhaps how testing for understanding could be conducted.

Everyone has a stake in the eradication of sexual abuse in order to eliminate illicit dominion by those who exercise their power wrongly over the vulnerable, who are inclined to believe that wielding such power is legitimate. To acknowledge society's stake in this task, education is fundamental to overcoming widespread ignorance and social myth, as well as to facilitate the economic and intellectual viability of disadvantaged adult CSA victims.

Teacher education curriculum and the role of general adult education is one means of addressing sexual abuse. Whether educators willingly address it or not, prevalence rates predict that eventually they will encounter a disclosure from someone who has endured sexual abuse as a child or they will instruct those who will, in time, encounter someone with CSA effects.

Adult education professionals believe that adults are autonomous, internally motivated, and able to self-define their learning needs. Educator's expectations that CSA affected adults can articulate their learning needs and concerns may be an overestimation of their capability, as well as the social acceptability in bringing up this uncomfortable topic (Chene', 1983). To paraphrase Eduard Lindeman (1961), the ideal adult education is defined not by subjects but by situations adults bring with them to learning encounters.

CHAPTER THREE

Methodology

Field Project Design

The intent of this project was to obtain baseline data concerning the extent to which professionals in adult learning settings screen participants for childhood sexual abuse, whether special or distinct services are offered on-site to adults with CSA history, and what competencies and needs are perceived by professionals to be important for CSA affected adults to achieve. After considering several research options, it was determined that the most efficient method for obtaining such baseline data was a mail survey to professionals in a representative sample of adult learning settings. This would permit some broad general conclusions to be drawn about services to adult learners with CSA histories that could then be refined for a more in-depth study at some future time.

Questionnaire Design

In an attempt to answer the research questions, a single page, one-sided questionnaire was developed inquiring about the screening and services for CSA adults available in a variety of adult education and adult learning settings. This allowed a comparison of the match between screening to services availability.

Services available to CSA adults in the sample settings were considered to index the pervasiveness, relevance, and applicability of CSA issues in learning situations. The achievement items were selected based upon the author's experiences, formal research the author had assisted with, and research findings. These were related to social and relational functioning, education levels, training

and employment needs, as well as basic life needs and skills, that support well-adjusted adult living. Well-adjusted adult living was considered to be a self-sufficient lifestyle which needs minimal social or professional service interventions. This also means the ability to exercise control and discipline in achieving socially endorsed adult goals, such as employment, education endeavors, and a safe life free of substance addiction.

Respondents were requested to reply to the following items listed (in underline). Explanatory notes follow some of the items to provide additional rationale for the item selection. These did not appear on the prepared questionnaire. (See Appendix B for a sample of the questionnaire).

- Do you ever screen adult learners or clients for childhood sexual abuse history?

- Does your workplace offer distinct or special services to adults with CSA history.

  [If NO] Please continue at the lower half of the page.***

  If the response was YES, the respondent moved on to the remaining items. When the response was NO, the respondent was directed by the asterisks (***) to proceed at the lower half of the page. There, the respondents who work in settings where services are not available to CSA adults were invited to return to the listed items to offer responses based on their experience.

The MAJORITY of Adults with CSA history served by this respondent need to achieve . . .

- Higher educational levels: more than secondary level

- Gainful employment

  Gainful employment is work that offers a living wage by which to support oneself and/or dependents.

- Basic adult education: at least GED or high school equivalency
- Vocational counseling
- Basic organizational skills

  CSA adults often come from families of origin that display low levels of organization, lower education levels, higher incidence of depression and below average scores for all relationship and personal growth dimensions (Long & Jackson, 1994). These characteristics may appear in the affected adult as lower skills in basic organization.

- Improved budgeting capability

  Diminished budgeting capability may be associated with revictimization and chronic poverty levels that relates to social competency for affected adults.

- Adequate parenting skills

  Parenting ability is affected by one's upbringing. In incestuous families dysfunctional family life and sexual abuse are highly correlated (Edwards, Alexander, 1992; Briere, 1987; Lipovsky & Saunders, 1989). Parker & Parker (1986) found that mistreatment by parents in the family of origin is highly predictive of abuse in the family of procreation. An adult who fails to deal with their abuse issues may abuse or fail to protect their own children (Davis, 1991).

- Ability to self-assess safe situations from high-risk situations

  Both men and women will subject themselves to risks non-abused individuals are apt to avoid (O'Connell, Leberg & Donaldson, 1990). A reduced capacity to discern danger or to esteem one's ability to get out of danger is among the effects of child abuse (Abraham,

1927; Davis, 1991; Salter/O'Connell, Leberg, Donaldson, 1990). Furthermore, heightened anger and aggression in men contributes to a higher incidence of violent crime, and the predisposition to behave in ways that precipitate familial dysfunction, such as with substance abuse and domestic violence (Chaffin, 1994).

- Long term counseling: longer than 9 months with at least weekly sessions

  In a therapeutic environment the victim can disclose under controlled conditions that are analogous to desensitization therapy (Lamb & Edgar-Smith, 1994). However, some criticize the long-term counseling bond as contributing to prolonging dysfunction. Yet another source of concern is that the Oedipal Complex explanation offered by a recanting Freud, (Masson, 1986) has lead some psychotherapists to discredit the origins of CSA symptomatology (Miller, 1990, Salter/O'Connell, Leberg, Donaldson, 1990).

- Family planning education

  This item was included to assess professional awareness of approaches being used by the State of Washington to reduce childbearing in disadvantaged public assistance recipients through family planning education. Selection of this item was influenced by State studies demonstrating child abuse with prolonged stay on public assistance ("Women in Transition," 1993; Roper & Weeks, 1993).

- Substance abuse interventions

  Substance addiction is associated with CSA adults who attempt to numb ruminative thought intrusion associated with PTSD symptomatology, (Herman, 1992) as a coping strategy built into survival mechanisms (Chaffin, 1994).

- Stable housing

  Child sexually abused youth may run away from home (O'Connell,

Leberg, & Donaldson, 1990). Child sexually abused women may become homeless in efforts to escape abusive situations.

- Stable income other than public assistance

- Do you make referrals to adults with CSA history to other service agencies? Please indicate the nature of your referrals. (Circle). professional name/ agency resource list / specific agency name

  The nature of referrals was asked about in order to reveal the respondent's awareness of other resources in their communities. Its inclusion in the questionnaire may have helped some respondents experience at least one affirmation in the event that denial or non-response prevailed with other questionnaire items, possibly improving return from the respondent.

Sample Selection and Questionnaire Distribution

A copy of the questionnaire was sent to a representative group of agencies offering adult learning support services. The settings selected to receive the project quetionnaire were assumed likely to be encountering adults with childhood sexual abuse history. The group included colleges and universities, human service agencies, counseling centers, and prison education sites. For most of the settings outside of mental health, encounters with CSA affected adults were assumed to be more or less incidental, not screened for, nor anticipated since learning support settings are not identified as typical stakeholders. A wide variety of settings were contancted in order to assess the scope of the settings that can help adults with CSA issues.

Distribution used a non-probability sample design incorporating convenience, snowball, and quota techniques. Most of the counseling and human services agencies were selected from among those in Snohomish

County, Washington. (A complete list of the sites surveyed is contained in Appendix C). Questionnaires were distributed over the months of January, February, and March, 1995.

One questionnaire was mailed per respondent setting accompanied by an appeal cover letter. To facilitate a response, the cover letter asked the recipients to distribute copies of the questionnaire, as appropriate, to colleagues they work with who might best respond to the questionnaire. It was suspected that not all the department heads sent the questionnaire would necessarily be familiar with the nature of client's issues being queried to the same degree as their subordinates. It was assumed that department heads would know best how to route the questionnaire.

To further engage the participants, they were invited to enclose their address if they would like to receive a copy of the abstract upon completion of the project. To return the questionnaire, the respondent was requested to fold the questionnaire in thirds, and tape it closed as it was pre-addressed to the author on the back. Respondents were required to pay the cost of return postage. Returns were marked off on the master list as they arrived at the writer's home address.

Adult education campus addresses were used as found published in the Washington Education Directory, (Krohn & Associates, 1990). Lists that had been acquired through the author's employment in social services and community volunteer work were utilized for the addresses of human service agencies and substance abuse treatment facilities in Snohomish County. These were entered into the database master list that was also used for the cover letter production, addressing the envelops, and for follow-up response data maintenance. A postcard reminder followed three weeks after the initial

mailing to non-responders.

The author personally conducted telephone questionnaires following the format of the mailed questionnaires for semi-structured interviews to reasonably local agencies non-responding to the initial mailing. Telephone follow-up to non-responders was done to improve data collection.

CHAPTER FOUR
Findings

Respondent Characteristics and Demographics

To ease comparisons between different types of settings, returns were categorized into one of four types: Mental Health Settings, Adult Education, Drug and Alcohol Treatment Settings, and a category for Others. Mental health providers were major private counseling and community mental health facilities. Adult education settings were Washington State colleges and universities. Drug and alcohol treatment settings were substance abuse recovery facilities and counseling programs that help adults manage substance abuse. Others comprised various human services agencies, including vocational counseling, developmental disability, adult shelter providers, prison education, and criminal justice settings. The category of Others were human services agencies which did not fit into one of the other categories, but who often address or broker learning activities on behalf of advancing the adults in their service populations.

This format of categorization also made response bias appear more clearly. For example, drug and alcohol treatment professionals serve a population that needs substance-abuse intervention, sometimes to the exclusion of other issue-items listed on the questionnaire. Naturally, their responses would affirm highly that substance-abuse intervention is an achievement need for their service populations. By categorizing the distinct professional settings contacted in this fashion biases are more readily identified by the high affirmation rates matching areas they specialize in.

Some returns represented the same worksite as the questionnaire was

copied and distributed to prospective respondents in the sample sites. This resulted in six responses from one university, four from another, and three from yet another. One setting in the Others category sent two returns. Overall, the norm was one respondent per setting.

Multiple respondents from the same worksite were counted in the data compilations as if the questionnaires were received from different sites because wide variations in responses rendered them distinct and separate. It was found that averaging the responses received from the same setting was not possible. Some questionnaire items were being answered in outright opposition by those in the same campus. Significantly, while some would affirm that screening was done, and services were available, others from the same setting denied that these were offered on-site. Indeed, individuals from the same campus typically responded so divergently that the author checked in triplicate to be certain that they came from the same address. There was no other indicator that could distinguish that some returns were from the same campus. Because this was not anticipated as a confounding variable, regarding these as separate settings seemed the only remedy by which to maintain these returns in the data results.

One site administrator declined participation because their staff duties were too broad (Statewide) to appropriately select professionals most likely to work with CSA adults in that organization. One college dean refused to participate or to invite others in that institution to complete the questionnaire.

Four sites were dropped from the site contact data list due to a lack of verification that they were functioning agencies during the time the project was conducted. (Therefore, of 112 sites sent questionnaires, 108 sites became the viable sample settings for the survey data. These are listed in Appendix C). The categories of Mental Health Providers, Drug and Alcohol Treatment

Facilities, Education settings, and human services agencies (respectively MHP, DrgRX, Ed's, and Others on the graphs) were ordered from the viable sites sent the project questionnaire. 77 respondents returned questionnaires

Some respondents from universities and colleges indicated that they worked in women's centers. It is interesting to note that the education settings that had women's centers were more likely to have on-site services. Also, these setting respondents offered less non-response replies to the questionnaire items. In addition, education setting respondents often wrote extensively in the margins of the returned questionnaires.

While it is usual for professionals to identify themselves on correspondence, many respondents did not identify their affiliation with the site, (e.g., instructor, counselor, dean, administrator, educator, contracted employee, and so on). In some cases it appeared that the respondents desired anonymity by the absence of their identification on the returned questionnaire. Because of the controversial nature of the subject matter, the questionnaire facilitated anonymity in order to heighten the likelihood of gaining participation.

By holding the services setting as the independent constant, returns were organized as to the primary mission being offered in the site. This was done since respondents could have been of any affiliation serving a variety of services functions at their worksite. For example, substance abuse treatment facilities often contract with mental health providers to work in treatment centers, and visa versa. So, if drug and alcohol treatment professionals were responding to the questionnaire from within the context of a mental health setting the return was nevertheless categorized as a mental health provider respondent. Likewise, when a psychologist was responding from an education site the return was categorized as an education setting respondent.

Table-1 demonstrates the distribution of respondents by category and total sample participation. The whole number and percentage of return participation computations are shown for the sample population contacted.

TABLE 1

PROJECT SAMPLE AND RESPONDENT DISTRIBUTION

s = Sample total: 108 n = Returned questionnaires t = Total returns: 77

# represented in s		% of s	# returns per category n	% returns per category n / # in s	% of t n / t
MHP:	11	10%	7	64%	9%
ED's	46	43%	43*	93%	56%*
DrgRx	23	21%	10	44%	13%
Others:	28	26%	17*	61%	22%*
Totals:	s = 108		t = 77		100%

*more than one return per site. Total returns of entire sample contacted for project = 71%

An interesting "control mechanism" incidentally emerged among mental health providers as the data was compiled. These respondents maintained affirmative alignment to every item on the questionnaire, and their responses helped to validate the selection and the meaning of the items. Their alignment served to support the validity and the implications for learning achievement needs often encountered among CSA affected adults.

Response to the Questionnaire Items

The questionnaire data was ordered into five life-achievements clusters as an aide to graphing the data. These are discussed in this section.

- Screening, and on-site services availability.

  The use of a screening tool used to assess child sexual abuse history in the adults they serve was obtained and measured. On the questionnaire, special or distinct services is meant services that assist an affected adult to explore and obtain guidance for their sexual abuse history issues with a professional who has educational background and access to knowledge about it.

- Education, training and employment achievement needs.

  This cluster includes the need to achieve higher education beyond secondary schooling, gainful employment as defined by work that satisfies the need for a living income, adult basic education instruction or the General Equivalency Degree, and vocational counseling.

- Social and relational development needs.

  This cluster includes improving parenting skills, drug and alcohol treatment interventions, the adult's ability to self-assess high risk situations, and the need to achieve a long-term counseling relationship as defined by attending weekly sessions over nine months or longer.

- Basic life skills and attaining basic life needs.

  This cluster includes the areas of improving basic organizational skill levels, improving budgeting ability, receiving family planning education, achieving adequate housing, and attaining income from a source other than from public assistance.

- Referral mechanisms.

  The presence and kind of referral to other services for CSA adults were queried. These were listed on the questionnaire by three categories: specific professionals' name, use of an agency resource list, and/or by a specific agency name. Respondents were asked to circle the appropriate type(s) of referral resource they use. They could circle all three categories, if appropriate.

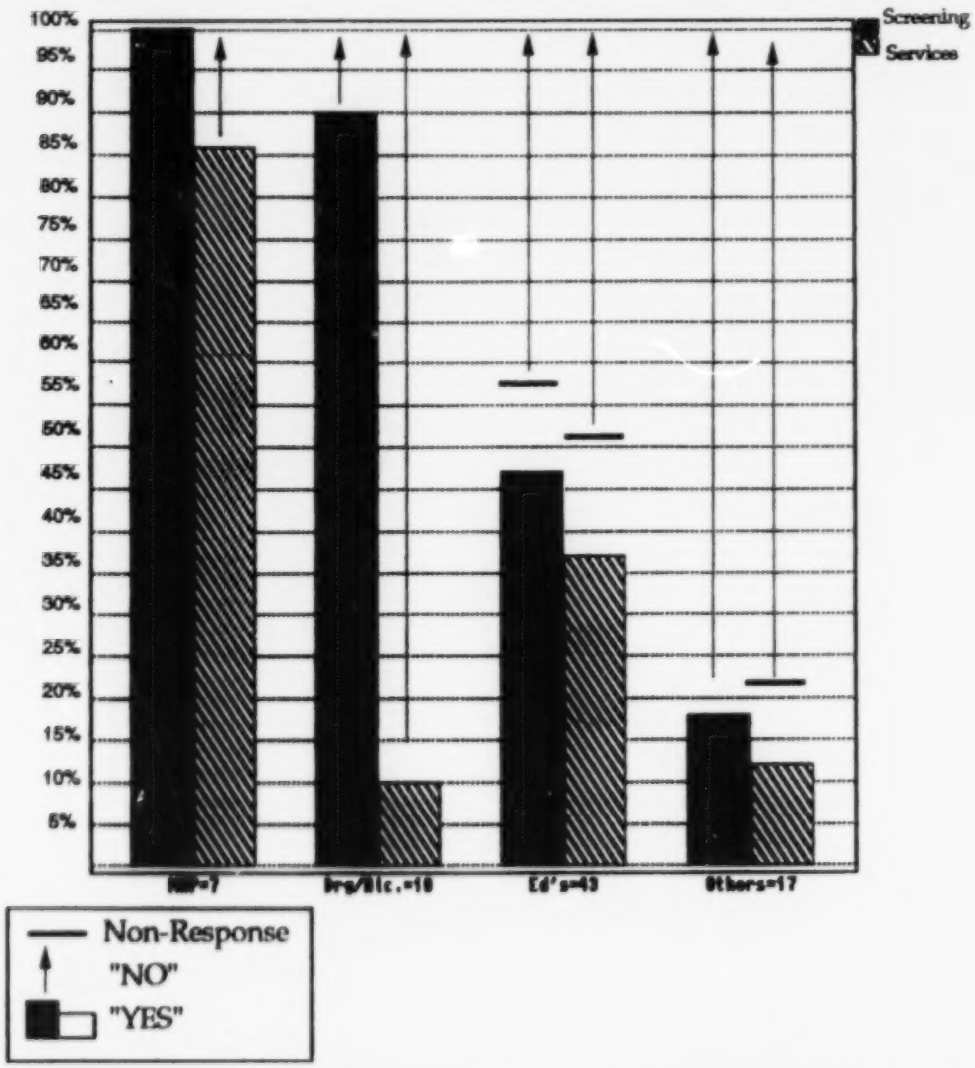
Graphs

The data was presented in bar graphs by percentage according to the four categories. On each graph that pertains to one of five achievement clusters, the vertical bars represent the percent of affirmative responses as designated by the key (setting categories) as it corresponds to each item on the questionnaire. For clarity in visualizing the data, each item is displayed by the percent of affirmation, (converted into vertical bars); non-response (converted into blank space above the respective bar until demarcated with a horizontal line directly above the corresponding bar); and negation (converted into vertical arrows from the percent non-response horizonal demarcation, if applicable, to the 100% demarcation limit),

The first four graphs are followed by brief summaries on the page(s) succeeding the graph. There are only three ways respondent responses are presented. These are YES, NO, and Non-Response (NR) options compiled according to each respondent category that corresponds to the questionnaire item per achievement cluster.

Respondents could select one of two answer options or could elect to leave the item blank. Blank items were treated as a non-response.

On-site Screening and Services Availability for CSA Adults



An example of how to read the graph follows. In the Others/"Screening" category, there were no non-responses. 82% replied that there is not a screening mechanism in use at their worksite. In the drug and alcohol treatment category, 10% responded YES that services are available, while 90% responded NO services are available. In the education settings 47% responded YES to a screening mechanism, 44% responded NO screening is conducted, and there was a 9% non-response rate to this item.

On-site Screening and Services Available to Adults with History of CSA

Mental Health Sites (n = 7)

Screening:

YES: 100% (7) NO: 0% (0) Non-Response: 0% (0)

Services:

YES: 86% (6) NO: 14% (1) Non-Response: 0% (0)

Drug and Alcohol Treatment Sites (n = 10)

Screening

YES: 90% (9) NO: 10% (1) Non-Response: 0% (0)

Services

YES: 10% (1) NO: 90% (9) Non-Response: 0% (0)

On follow-up interviews for this setting, it was found that applications may expose CSA history. The question is phrased, "Have you experienced trauma in childhood?" Or, "Have you experienced abuse (physical, emotional, sexual) during your childhood?"

Educators (n = 43)

Screening

YES: 47% (20) NO: 44% (19) Non-Response: 9% (4)

Services

YES: 37% (16) NO: 52% (22) Non-Response: 11% (5)

On interviews, services are available in context of counseling centers, generally through women's centers services. Screening is often informal. Many replied that CSA history is volunteered by students, and that they could not say that a screening mechanism exists for the purpose of directing students to services.

Others (n = 17)

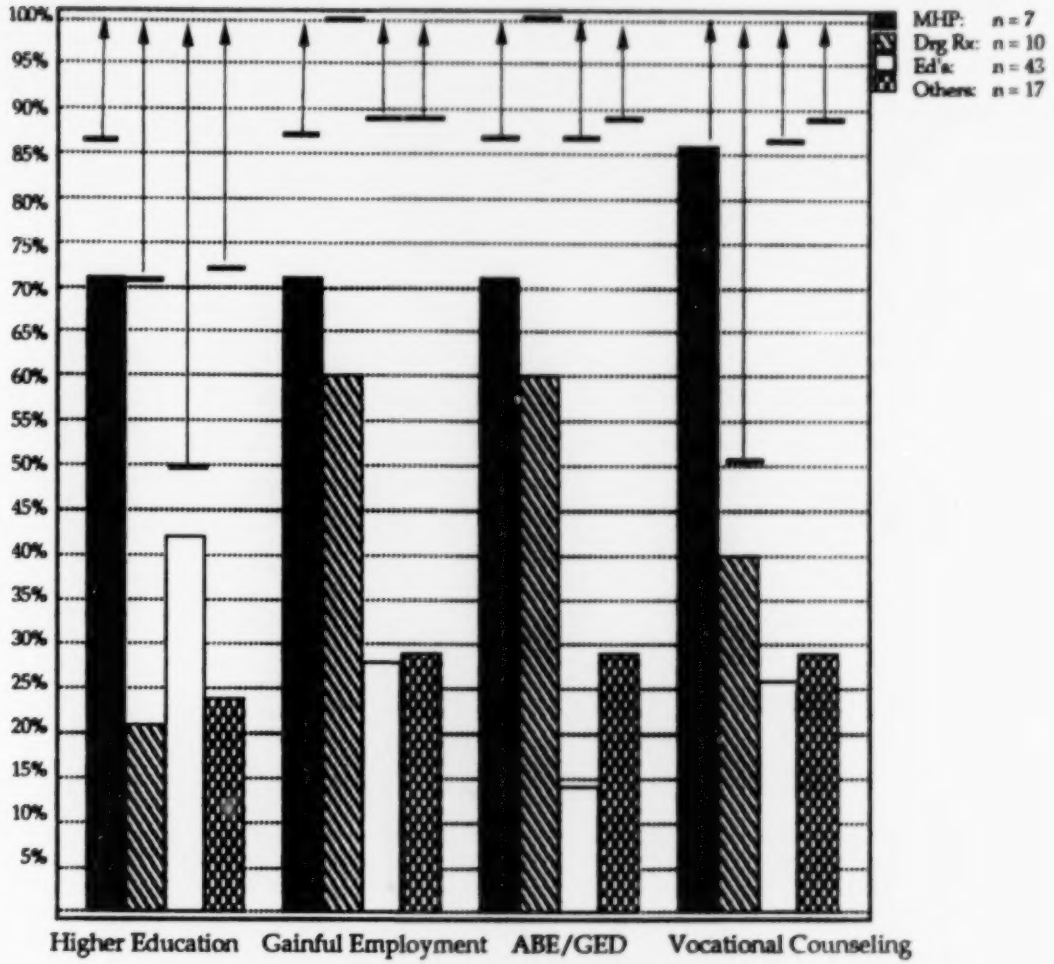
Screening

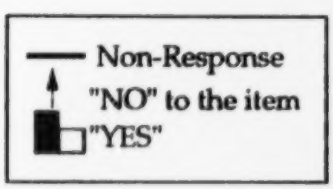
YES: 17% (3) NO: 82% (14) Non-Response: 0% (0)

Services

YES: 13% (2) NO: 82% (14) Non-Response: 6% (1)

Education, Employment and Vocational Counseling Needs





Bars represent percent "Yes" responses, horizontal lines above the bars are the percentage rates of non-response, and arrows represent percent "NO" responses to the items.

Education, Employment and Vocational Counseling Needs Graph

Mental Health Providers (n = 7)

Higher Education
YES: 72% (5) NO: 14% (1) Non-Response: 14% (1)

Gainful Employment
YES: 72% (5) NO: 14% (1) Non-Response: 14% (1)

ABE/GED
YES: 72% (5) NO: 14% (1) Non-Response: 14% (1)

Vocational Counseling
YES: 86% (6) NO: 14% (1) Non-Response: 0% (0)

DrgRX (n = 10)

Higher Education
YES: 20% (2) NO: 30% (3) Non-Response: 50% (5)

Gainful Employment
YES: 60% (6) NO: 0% (0) Non-Response: 40% (4)

ABE/GED
YES: 60% (6) NO: 0% (0) Non-Response: 40% (4)

Vocational Counseling
YES: 40% (4) NO: 50% (5) Non-Response: 10% (1)

Educators (n = 43)

Higher Education
YES: 43% (18) NO: 5% (3) Non-Response: 52% (22)

Gainful Employment
YES: 28% (12) NO: 12% (5) Non-Response: 60% (26)

ABE/GED
YES: 14% (6) NO: 14% (6) Non-Response: 73% (31)

Vocational Counseling
YES: 26% (11) NO: 14% (6) Non-Response: 60% (26)

Others (n = 17)

Higher Education
YES: 24% (4) NO: 28% (5) Non-Response: 48% (8)

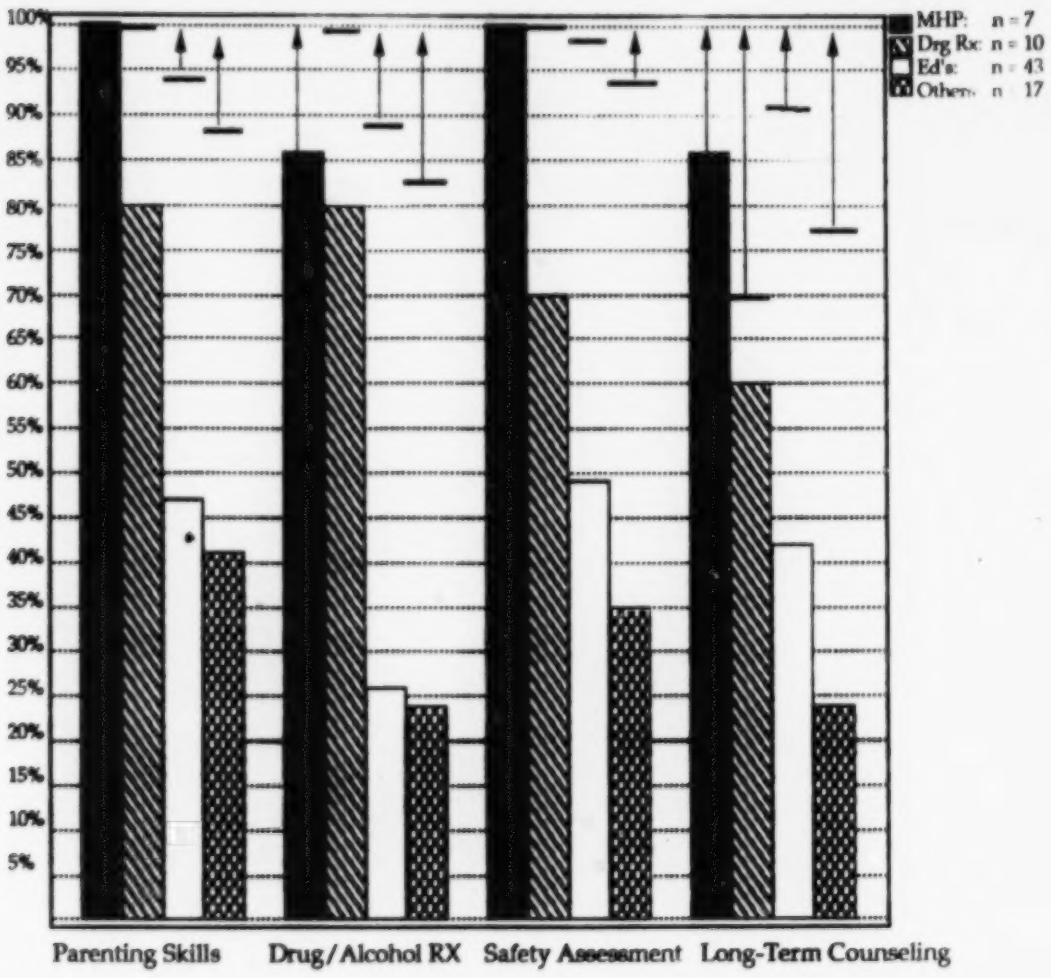
Gainful Employment
YES: 29% (5) NO: 13% (2) Non-Response: 58% (10)

ABE/GED
YES: 29% (5) NO: 13% (2) Non-Response: 58% (10)

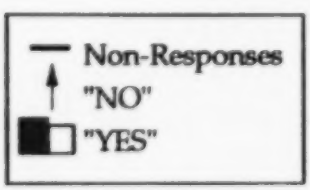
Vocational Counseling
YES: 29% (5) NO: 13% (2) Non-Response: 58% (10)

Half of those in various human services did not respond to the achievement items in this cluster. Little over 1/4 of the Others category affirm these items are achievement needs among CSA adults they encounter.

Social and Relational Development Needs



Achievement Needs



Bars represent "Yes" responses, horizontal lines above the bars represent the percentage rates of non-response, and the arrows are percent "NO" responses to the relevant items.

Social and Relational Development Needs

Mental Health Providers (n = 7)

Parenting Skills Improvement
YES: 100% (7) NO: 0% (0) Non-Response: 0% (0)

Drug and Alcohol Treatment Interventions
YES: 87% (6) NO: 13% (1) Non-Response: 0% (0)

Ability to Self-Assess Safe Situations over High-Risk Situations
YES: 10% (7) NO: 0% (0) Non-Response: 0% (0)

Need to Obtain Long-Term Counseling
YES: 87% (6) NO: 13% (1) Non-Response: 0% (0)

Most mental health providers affirmed the achievement needs in social and relational development areas.

Drug and Alcohol Treatment Providers (n = 10)

Parenting Skills Improvement
YES: 80% (8) NO: 0% (0) Non-Response: 20% (2)

Drug and Alcohol Treatment Interventions
YES: 80% (8) NO: 0% (0) Non-Response: 20% (2)

Ability to Self-Assess Safe Situations over High-Risk Situations
YES: 70% (7) NO: 0% (0) Non-Response: 30% (3)

Need to Obtain Long-Term Counseling
YES: 60% (6) NO: 10% (1) Non-Response: 30% (3)

Educators (n = 43)

Parenting Skills Improvement
YES: 47% (20) NO: 7% (3) Non-Response: 47% (20)

Drug and Alcohol Treatment Interventions
YES: 26% (11) NO: 11% (5) Non-Response: 63% (27)

Ability to Self-Assess Safe Situations over High-Risk Situations
YES: 49% (21) NO: 2% (1) Non-Response: 49% (21)

Need to Obtain Long-Term Counseling
YES: 42% (18) NO: 9% (4) Non-Response: 49% (21)

Others (n = 17)

Parenting Skills Improvement

YES: 41% (7) NO: 12% (2) Non-Response: 47% (8)

Drug and Alcohol Treatment Interventions

YES: 24% (4) NO: 18% (3) Non-Response: 58% (10)

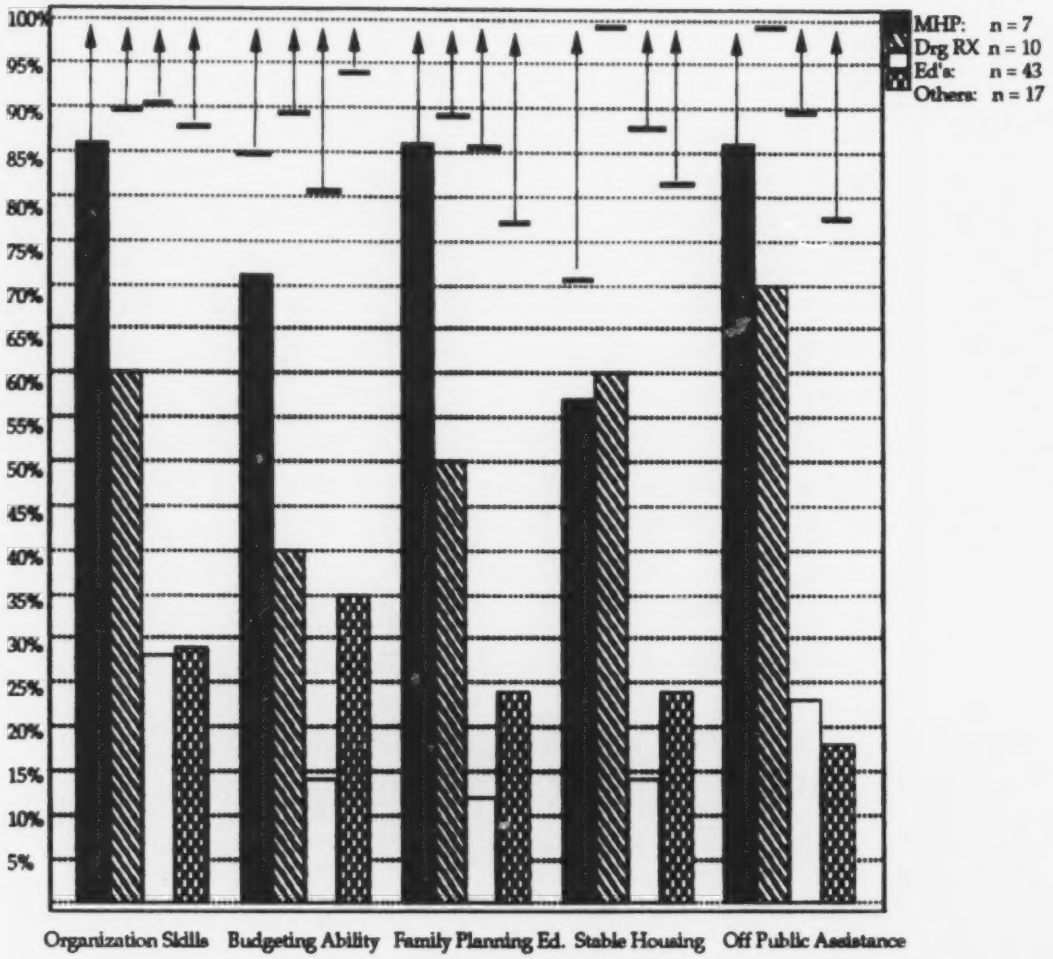
Ability to Self-Assess Safe Situations over High-Risk Situations

YES: 35% (6) NO: 6% (1) Non-Response: 59% (10)

Need to Obtain Long-Term Counseling

YES: 24% (4) NO: 24% (4) Non-Response: 52% (9)

Basic Life Skills and Basic Life Needs



Bars represent "Yes" responses; horizontal lines above the bar represent the percentage rates of non-response, and arrows are percent "NO" replies to the items.

Basic Life Skills and Basic Life Needs

Mental Health Providers (n = 7)

Organizational Skills Improvement
YES: 86% (6) NO: 14% (1) Non-Response: 0% (0)

Budgeting Ability Improvement
YES: 71% (5) NO: 14% (1) Non-Response: 14% (1)

Family Planning Education
YES: 86% (6) NO: 14% (1) Non-Response: 0% (0)

Obtaining Stable Housing
YES: 57% (4) NO: 14% (1) Non-Response: 29% (2)

Obtaining Income Other than Public Assistance
YES: 86% (6) NO: 14% (1) Non-Response: 0% (0)

Drug and Alcohol Treatment Professionals (n = 10)

Organizational Skills Improvement
YES: 60% (6) NO: 10% (1) Non-Response: 30% (3)

Budgeting Ability Improvement
YES: 40% (4) NO: 10% (1) Non-Response: 50% (5)

Family Planning Education
YES: 50% (5) NO: 10% (1) Non-Response: 40% (4)

Obtaining Stable Housing
YES: 60% (6) NO: 0% (0) Non-Response: 40% (4)

Obtaining Income Other than Public Assistance
YES: 70% (7) NO: 0% (0) Non-Response: 30% (3)

Educators (n = 43)

Organizational Skills Improvement
YES: 28% (12) NO: 9% (4) Non-Response: 63% (27)

Budgeting Ability Improvement
YES: 14% (6) NO: 19% (8) Non-Response: 67% (29)

Family Planning Education
YES: 12% (5) NO: 14% (6) Non-Response: 74% (32)

Obtaining Stable Housing
YES: 14% (6) NO: 12% (5) Non-Response: 74% (32)

Obtaining Income Other than Public Assistance
YES: 23% (10) NO: 9% (4) Non-Response: 67% (29)

Others (n = 17)
Organizational Skills Improvement
YES: 29% (5) NO: 12% (2) Non-Response: 59% (10)

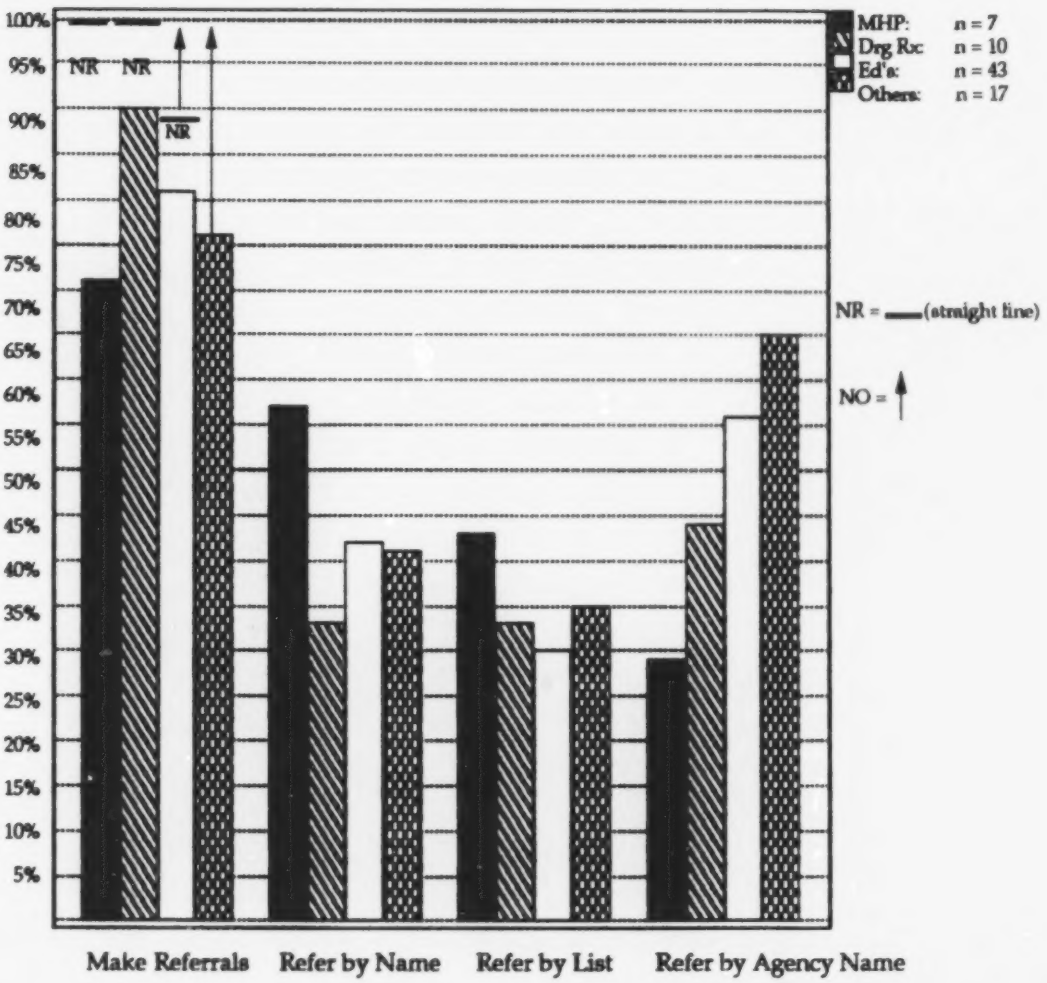
Budgeting Ability Improvement
YES: 35% (6) NO: 6% (1) Non-Response: 59% (10)

Family Planning Education
YES: 24% (4) NO: 24% (4) Non-Response: 53% (9)

Obtaining Stable Housing
YES: 24% (4) NO: 18% (3) Non-Response: 59% (10)

Obtaining Income Other than Public Assistance
YES: 18% (3) NO: 24% (4) Non-Response: 59% (10)

Referral Graph: Nature of Referrals Respondents Offer to CSA Adults



For the first bar set, the legend (horizonal axis) identifies the categories of respondents. The labels (vertical axis) identify the nature of the referrals offered in the respondent categories. This graph shows the percentage that the respondents referred by naming the professional recommended, by using a prepared list, or by agency name. All or some of these approaches could have been indicated by the respondents. For the specific nature of referrals used non-responses and NO responses were irrevelant. (This is the only item on the questionnaire that presented sub-categories from which to select).

Answering the Project Questions

The project questions are answered below by the findings in context of each question. In this section, the data findings were compiled for the entire respondent group as a set.

To what extent do adult learning support services settings screen for the presence of CSA?

51% of the sites responding to the questionnaire screen adults for CSA history. (About one in two learning settings and learning support settings that participated in the project screen for childhood sexual abuse history). This data may have been weighted by the intake application questions that ask if the applicant has ever experienced childhood trauma or abuse as part of obtaining a client's history. Some respondents, on follow-up, stated that this information may not be directly obtained but rather is exposed through indirect, global questions. Nevertheless, this information about a client helps providers to direct them to resources that apply.

Are special or distinct services for adults with CSA history offered in these settings?

32% of the project respondents replied that services are available for CSA affected adults. This data may underrepresent the actual services available to CSA adults since some respondents reported problems interpreting the qualifiers "special or distinct." At the least it can be understood that this figure reflects the minimum percentage of services available in the settings that participated.

When services are offered, what issues are perceived by professionals to be important for CSA adults to achieve? If no on-site services are offered, what issues are perceived important for CSA adults to achieve?

In answer to these project questions, YES, NO, and Non-response

data is shown below for the entire set of respondents (n = 77). Table 2 shows the questionnaire item response data rated in descending order (from the highest rate per item to lowest) based upon affirmative responses.

TABLE 2

RESPONSE PERCENTAGES OF PROJECT PARTICIPANTS (n = 77)

Items on the questionnaire	YES	NO	NR
Offering referrals to alternate professionals:	81%	10%	9%
Improving Parenting Ability:	55%	6%	39%
Ability to self-assess safe situations from high-risk situations:	53%	2%	44%
The need to obtain long-term counseling:	44%	13%	43%
Higher education:	38%	15%	47%
Receiving substance abuse interventions:	38%	11%	51%
Organizational Skills:	38%	10%	52%
Gainful Employment:	36%	11%	53%
Receiving income other than Public Assistance:	34%	11%	55%
Vocational Counseling:	34%	8%	58%
Adult Basic Education or GED:	29%	19%	52%
Budgeting Ability:	27%	15%	58%
Family Planning Education:	26%	16%	58%
Obtaining Stable Housing:	26%	12%	62%

NR = Non-Response

Will the findings suggest that adults with CSA history comprise a distinct learning population?

The findings suggest that certain achievement needs strongly characterize many CSA adults. Appropriate referrals, parenting ability, safety issues, getting long-term counseling, obtaining higher education, receiving substance abuse treatment interventions, and developing organizational skills were needs that were rated the highest. A distinct learning population may be revealed with needs related to social and family normalcy, personal insight and knowledge of the self (obtainable in counseling and therapy), and ways they can achieve higher education endeavors. The latter implicates higher education settings as stakeholders that could be invited into the preventive and social strategies that address and inform citizens about CSA's social ramifications. This finding also implicates the relevance of developing curriculum about CSA adult long-term effects for all higher education environments.

It was no surprise that mental health settings offered the most access to services, but it was most interesting that adult students can find supports for CSA issues on higher education campuses. This offers evidence that overlapping CSA symptomatology and issues are encountered in many professional domains. There is very little broadcasting or advertisements in most higher education settings that announces these as stakeholders or adjunctive resources for affected CSA adults.

Nonetheless, the project findings suggested that knowledge deficits among professionals prevailed in regards addressing CSA adult achievement needs. This was significant for every setting except in mental health. This is one of the ways the high rates of non-response to the listed items can be interpreted. As a whole, about half of the repondents that replied did not answer

the listed items.

Services were most accessible in mental health and education settings. While services were affirmed at just below the 40th percentile in education settings, the difference gap between screening and services is dramatically less in education settings than it is in drug and alcohol treatment settings. Also, 50% of the education setting respondents affirmed achievement deficits among the majority of those with CSA history. Remarkably, over one-third of the responding education settings offer on-site services for affected CSA adults.

Interestingly, human services settings presented with the highest non-response rates and offered much lower rates of on -site service availability. This could suggest that stronger efforts be made to place CSA services in programs administered by front-line human services. (Here, it is important to note that child protective agencies were not invited into the study. It should also be stated, in all fairness, that settings that don't screen or serve those with a history of CSA may not endorse that this subject has much bearing on the nature of assistance provided. Indeed, this was suggested by one professional during follow-up of vocational services settings).

Drug and alcohol settings affirmed in high percentages deficits of achievement gains observed among CSA affected adults. Some stated that causative or precursor issues to addictive behaviors were secondary since the primary objective for their settings was to help people obtain sobriety. Furthermore, while childhood sexual abuse was observed as a liability for many in their service population, it was not usually managed in treatment settings because it is regarded as a hot-bed of intricate issues that an unskilled counselor could ignite, thereby compromising fragile sobriety. Some offered

the caution that such issues be managed only by specialists and only after a sufficient length of time spent sober had been sustained. However, some respondents deplored this rationale, stating that it leaves many recovering addicts without the necessary support and guidance while they are yet surrounded by a controlled enviornment. For some respondents, the tendency to avoid the client's history of sexual abuse in current drug and alcohol treatment modalities was controversial. It was observed that, in these settings, referrals are strongly relied upon.

81% of the respondents offer referrals into the community for supports not available in the respondents' worksites. Not shown in TABLE 2 were that 42% present a referral by name; 32% offer the client the use of a referral resource list, and 53% refer to a particular agency that can potentially serve the needs of the client. While those in education, human services, and drug and alcohol treatment settings respond that they refer to mental health agencies, the mental health providers responded that they refer their clients to other agencies for specific achievement needs. Most reciprocally refer their clients into the settings of the other professionals included in this project.

Mental health settings were included in the study even though it is common knowledge that these participants screen and serve those with negative CSA affects. They affirmed overwhelmingly the achievement needs listed on the questionnaire. Another rationale for their inclusion in the project survey was that they serve an important role in helping adult learners attain higher states of personal development. They also helped verify as sound the author's observations of achievement deficits not mentioned in the literature, such as family planning and getting off welfare.

CHAPTER FIVE
Conclusions and Recommendations

Overview of the Project

The purpose of the project was to establish a baseline about services and professional awareness of CSA symptomatology in higher education and selected adult learning support settings. Exploring what professionals in these settings know about CSA long-term effects was expected to shed light on the incidence and perceptions of professionals encountering negatively affected CSA adults in their work-settings. This would also indicate the pervasiveness to which CSA history is perceived by diverse professionals to be related to adult achievement needs. Hence, commonly observed learning needs seen through different professions may hint at the possibility that CSA history contributes to distinct learning needs in the affected population.

The project was undertaken to clarify if it is of value that educators, and those who support, engage, and/or assign adults to learning activities be able to recognize CSA negative effects. It was postulated that enduring issues rooted in CSA history can and do hinder the potential adult learner.

Based on these assumptions, the findings support that CSA history can predict supports may need to be resourced on behalf of affected adults in learning and learning support settings. Another way to view the results is as a baseline assessment for the settings in which education for both professionals and the victims they encounter would be helpful. Since the findings demonstrate that CSA symptomatology does spill into many service systems it appears that education for professionals about CSA is relevant to most service occupations.

Since nearly half of the respondents could not address the achievement needs of CSA adults, the findings also suggest that not enough is being disseminated about the broad-reaching effects of CSA. It can be assumed that some settings may fail to support CSA adults in ways known to be helpful for those with negative effects.

The project noted that, traditionally, the terrain of CSA is a mental health and criminal justice concern. Yet education settings sometimes screen and serve adults with a history of CSA. Because there was no empirical recommendation that they do so in current research literature, perhaps a grassroots initiative was detected regarding the needs of CSA adult learners. This interest may be just discernible now as an educator concern, insofar as CSA recovery goes. Why adult education settings are not more conspicuous as stakeholders of CSA outcome in education research or psychosocial literature is curious. Nonetheless, it appears that some learning settings recognize the impact of negative childhood events and offer assistance to help those in need of making sense out of their tribulations.

The fact that CSA-issue services are sometimes accessible in learning support settings demonstrates that supportive curriculum and inservices about CSA effects on adult learners is relevant to some adult educators and learning support professionals. Additionally, education administrations that endorse and recoup costs associated with supportive services and financial assistance programs should take notice of affected adults' achievement needs.

CSA effects are of concern to education supporters and adult educators as a consequence of delayed disclosure by the child victim, because of interrupted schooling for affected youth, and because it leads to a high incidence of adults being disadvantaged from day one out of their homes of

origin. The project's findings suggest that CSA history predisposes negatively affected adult learners to comprise a distinct learning support-needs population. However, not only are education and learning-support professionals vague stakeholders of CSA intervention, but so also are adult education theorists seemingly unaware of CSA effects on learning participation.

Problems with the Project

Arranging the data into categories of professionals by site became helpful as the questionnaires were returned. Initially, the questionnaires were sent to a single group: those believed likely to have a stake in adult education and/or in positions to provide education or training program supports. Shortly after receiving responses, the professional categories emerged relevant to response biases according to settings. To help response bias appear more clearly the data was organized according to the setting from which it was received. This helped with the problem that most respondents did not identify their titles on the returns and the originating setting was all that was known.

Ordering the returns by site rather than titles may have obscured the service functions or affiliations of some respondents. For example, some mental health professionals work in education counseling centers, and some educators work in human services settings. Many prisons hire mental health providers and adult educators, but the ordering of the respondents from prison settings fell into the Others category.

Adult education occurs in a vast array of settings. Where the lines would be drawn for obtaining data from diverse settings that serve CSA adult learners was confounded by the debate of what constitutes an adult education setting. Sending the questionnaire to higher education campuses only would

have excluded learners in less conventional adult learning situations. Information about relevant professional perceptions of CSA adults in alternate settings would have been left out. In addition, many CSA adults never enroll in higher education settings.

Another problem occurred in compiling data. Some settings sent more than one return as a result of the recipient copying and distributing it to prospective repondents in their work-sites. Although this occurred with only four sites, involving 15 returns in all, (three sites were universities or colleges, and one was from the Others category), it needed to be managed so as not to skew the results.

At first, responses from the same settings were averaged to reflect a composite percentage as if the returns were from one site. This was abandoned because it was observed that unless one knew that these returns were from the same setting, one couldn't discern it, so divergent were the responses. For example, one respondent would affirm a screening mechanism and services were available and another would deny both. Either respondents were unaware of the services available in other departments in the same setting, or perhaps they responded to the questionnaire as if it related only to their professional scope of duties. This confounding variable was partially resolved by compiling the respondent data as if it emerged from different sites.

On follow-up, it was found that some respondents had difficulty maintaining clarity with the term MAJORITY of CSA Adults on the questionnaire. The author was told on more than one follow-up that all people should achieve the listed needs. Therefore, some felt it awkward to leave an item blank, nor were they comfortable replying NO to these items. However, several respondents were able to participate once the qualifier of MAJORITY

was explained that it meant 51% or more of CSA adults in a population made up of CSA adults.

Non-responses to some items may have resulted from the professionals' a.) Lack of information to form an opinion; b.) Not receiving history data about their service populations; and/or c.) They neither agree nor disagree that the items listed had relevance to CSA adult achievement needs.

Responding NO to the items may be interpreted as either: "The majority of CSA affected adults do not need to achieve these needs," or, "no, this item does not relate to CSA affected adults at all." The project did not obtain clarification on these distinctions. Affirmative responses were overall the most meaningful data collected by the project. Non-responses and NO replies must be viewed with caution as to how the respondents interpreted their response.

As to the meaning respondents gave to the qualifier that services were special or distinct, language was a problem. Operationalizing the terms special and distinct on the questionnaire would have been helpful. Some kind of qualifier was needed. (It was not appropriate to ask, "are CSA adults offered services in this worksite?" And, it seemed unethical to cause a respondent to make reply that CSA adults were not receiving services the sites were supposed to deliver). The qualifiers of special and/or distinct were intended to assist the respondent to answer whether issues rooted in CSA were managed at their worksite on request. The qualifiers were intended to identify settings that don't address issues originating in childhood sexual abuse.

For some, special or distinct seemed to have been taken to mean something extra provided for some but not others, perhaps insinuating a form of discrimination. On follow-up, it was found that these few respondents

reacted to the qualifiers in recognition of the criticisms that current approaches tend to stigmatize those with CSA history.

Recommendations

Being able to recognize symptomatology would allow the educator to make informed assumptions about the supports, validation, and learning needs of developing individuals in their service populations. To the detriment of empirical research, it appears awkward to give adequate context to fragments of the victim's story when only small portions of the page are allotted to the voices of the actual research subjects. This is the basis for an argument that we investigate strategies for participatory research among disadvantaged and abused people.

The project study worksites that offered very different replies from one another suggests that interdepartmental staff orientations may help staff to be aware of various department services on the same campus. Various on-site services available to clients could be data-based for all staff to access. Professionals in various departments should stay up to date with what is available for their service populations from within their own agency. This would likely improve service access and utilization of available on-site resources.

CSA adults must often be able to access more systems than are available through any one setting. For this reason, it is suggested that the range of professionals contacted in this study prioritize service access strategies. Referrals should be made simple to resource and service availability information widely disseminated. Most of the professionals in the project relied strongly on the mental health services in their communities to

assist clients in need of guidance for CSA issues. Agencies that offer learning agendas should strive to maintain a regular association with settings that offer low-cost services to CSA adults in the event that services are not available on-site.

Screening for a history of CSA can prompt the professional to further assess the client's volition, abilities, and resources helpful for the affected adult to carry out a successful development plan. Especially, awareness of CSA issues is important where victims are mandated to participate in self-development services. Education materials can be made more accessible via lending libraries supplied with self-help literature. Classrooms can discuss CSA symptomatology to disseminate what is known about CSA into populations who may inform their families and communities.

Adult educators should become familiar with the effects of CSA in order to anticipate learning needs and to prepare victims for stressors that typically present in learning environments. For example, awareness and insight into the nature of how enduring CSA effects may impact professional ethics and socialization in specific career or job classifications should be integral to designing program entrance criteria. Furthermore, adult educators need information about how education practices can help developing adult learners experientially test treatment processes in learning situations.

Validation is fundamentally the most important aspect to adult recovery. Adults who lacked resources and supports with issues while a child or teen often find there are still inadequate supports and avenues to help them validate the search for meaningful growth through their barriers as adults. A broad community response and a multi-disciplinary approach are called for to mediate truly the negative effects of CSA. Support groups and certain forms of

community activism, in particular, offer significant opportunities for recovery and change as "forums of social learning" (Alexander, 1994; Herman, 1992; Sgrol, 1988).

Closing Comments

Adult educators have a stake in learners' mental well-being and their ability to participate wholeheartedly in learning activities. Adult education theories of facilitation and participation and the processes of a democratic education holds ideal the emancipation of knowledge (Giroux & McLaren, 1986). For the less fortunate, Rubenson (1989) offers this criticism of adult education theory:

> A system of adult education that implicitly takes for granted that the adult is a conscious, self-directed individual in possession of the instruments vital to making use of the available possibilities for adult education–a system that relies on self-selection to recruit the participants–will by necessity widen, not narrow, the educational and cultural gaps in society . . . Conflict theorists maintain that factual opportunities to participate are far from equal. (p. 65)

Adult educators help learners to identify the mind-view they have about the world, thus challenging the learner to draw upon prior experiences, but not because trauma or past events need revisiting to bring about healing. Understanding and exploring past events can help us make sense of where and who we are now, which helps us to see better into the future and more meaningfully into the past.

From myth we can derive meaning and symbols of the human condition. From silence, secrecy, and omission we derive oppression. How society regards its members' enrichment requires critical thinking and reflection. Critical thinking is the domain of educators. Knowing how to get learners to think critically is a large part of what adult education is about (Brookfield, 1987). This capacity to think critically is what this project assumed to be most at risk in the persons who endure child sexual abuse.

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APPENDIX A: Complex Post-Traumatic Stress Disorder

by J. Herman M.D. (1992).

(Extracted from Trauma and Recovery. BasicBooks, a division of HarperCollins Publishers, Inc.: New York, p. 121). Reprinted with permission.

1. A history of subjection to totalitarian control over a prolonged period (months to years). Examples include hostages, prisoners of war, concentration-camp survivors, and survivors of some religious cults. Examples also include those subjected to totalitarian systems in sexual and domestic life, including survivors of domestic battering, childhood physical or sexual abuse, and organized sexual exploitation.

2. Alteration in affect regulation, including
   - persistent dysphoria
   - chronic suicidal preoccupation
   - self-injury
   - explosive or extremely inhibited anger (may alternate)
   - compulsive or extremely inhibited sexuality (may alternate)

3. Alterations in consciousness, including
   - amnesia or hypermnesia for traumatic events
   - transient dissociative episodes
   - depersonalization/derealization
   - reliving experiences, either in the form of intrusive post-traumatic stress disorder symptoms or in the form of ruminative preoccupation

4. Alterations in self-perception, including
   - sense of helplessness or paralysis of initiative
   - shame, guilt, and self-blame
   - sense of defilement or stigma
   - sense of complete difference from others (may include sense of specialness, utter aloneness, belief no other person can understand, or nonhuman identity)

5. Alterations in perception of perpetrator, including
   - preoccupation with relationship with perpetrator (includes preoccupation with revenge)

- unrealistic attribution of total power to perpetrator (caution: victim's assessment of power realities may be more realistic than clinician's)
- idealization or paradoxical gratitude
- sense of special or supernatural relationship
- acceptance of belief system or rationalizations of perpetrator

6. Alterations in relations with others, including
   - isolation and withdrawal
   - disruption in intimate relationships
   - repeated search for rescuer (may alternate with isolation and withdrawal)
   - persistent distrust
   - repeated failures of self-protection

7. Alterations in systems of meaning
   - loss of sustaining faith
   - sense of hopelessness and despair

Appendix B: Sample Questionnaire

The purpose of this survey is to collect data about the perceived learning needs of adults who have a history of childhood sexual abuse. This is part of a needs assessment for my graduate research thesis. Kindly offer a timely response. If you would like a copy of the results compiled be sure to print your name and address at the bottom of the survey. Fold in thirds, tape and mail back to the address listed on the other side of this page. If you can send other information which may be useful to this research it will be most appreciated. The whereabouts of any existing data you know of will further this research. Thank you very much for your time. Karen Redfield

YES NO

[ ] [ ] Do you ever screen adult learners or clients for childhood sexual abuse history.

[ ] [ ] Does your workplace offer distinct or special services to adults with CSA history.

Please continue at the lower half of the page.***

The MAJORITY of Adults with CSA history served by this respondent need to achieve:

[ ] [ ] higher educational levels: more than secondary level

[ ] [ ] gainful employment

[ ] [ ] basic adult education: at least GED or high school equivalency

[ ] [ ] vocational counseling

[ ] [ ] basic organizational skills

[ ] [ ] improved budgeting capability

[ ] [ ] adequate parenting skills

[ ] [ ] ability to self-assess safe situations from high risk situations

[ ] [ ] long term counseling: longer than 9 months with at least weekly sessions

[ ] [ ] family planning education

[ ] [ ] substance abuse interventions

[ ] [ ] stable housing

[ ] [ ] stable income other than public assistance

«««

[ ] [ ] Do you make referrals to adults with CSA history to other service agencies?
Please indicate the nature of your referrals.

BY (Circle): professional's name / agency resource list / specific agency name

*** Although you have indicated that you do not work specifically with this population of adults you may have valuable input. Please, if you feel comfortable responding to the items listed above based on your personal experiences or observations, professionally or otherwise, your opinion is greatly appreciated.

This respondent would like a copy of the survey results or thesis abstract on completion.

Send to: _____

_____

_____

(Only one copy will be sent per agency).

Appendix C

Field Project Sites Contacted

Site	City	State/Zip
A Solution Recovery Program Inc.	Everett	WA 98203
ARC	Everett	WA 98201
Antioch University	Seattle	WA 98121
Bellevue Community College	Bellevue	WA 98009-2037
Catholic Community Services	Everett	WA 98201
Cedar Creek Corrections Center	Littlerock	WA 98556
Central Washington University	Ellensburg	WA 98026
Centralia College	Centralia	WA 98531
City University	Bellevue	WA 98008
Clallam Bay Correction Center	Clallam Bay	WA 98236
Clark College	Vancouver	WA 98663
Columbia Basin College	Pasco	WA 99301
Community College District 11	Spokane	WA 99207-5499
Community College District 6	Seattle	WA 98122
Community Corrections	Everett	WA 98208-2620
Conquest Center	Edmonds	WA 98026
Cornish College of the Arts	Seattle	WA 98102
Counterpoint	Lynnwood	WA 98036
Crisis Center	Bellingham	WA 98225
Crosby Enterprises, Inc.	Lynnwood	WA 98036
Division of Vocational Rehabilitation	Olympia	WA 98504
Division of Vocational Rehabilitation	Everett	WA 98201
Eastern Washington Pre-Release	Medical Lake	WA 99022
Eastern Washington University	Cheney	WA 99004
Edmonds Community College	Lynnwood	WA 98036
Everett Community College	Everett	WA 98201
Everett Gospel Mission	Everett	WA 98201
Evergreen Counseling Center	Everett	WA 98201

Site	City	State/Zip
Evergreen Manor	Everett	WA 98201
Family Counseling Services	Everett	WA 98205
Focus	Everett	WA 98204
Geiger Corrections Center	Spokane	WA 99219
Gonzaga University	Spokane	WA 99258-0001
Grays Harbor College	Aberdeen	WA 98520
Green River Community College	Auburn	WA 98002
Heritage College	Toppenish	WA 98948
Highline Community College	Des Moines	WA 98000
Indian Ridge Corrections Center	Arlington	WA 98223
Job Therapy of Snohomish Co.	Snohomish	WA 99290
KAIROS Counseling Services	Snohomish	WA 98290-2815
Lakeside Recovery Center	Everett	WA 98201
Larch Corrections Center	Yacolt	WA 98675
Lower Columbia College	Longview	WA 98632-0310
Luther Child Center	Everett	WA 98203
Marvel Industries	Everett	WA 98201
McNeil Island Corrections Center	Steilacoom	WA 98388
Mental Health Services	Everett	WA 98201
Norcross Clinic, Inc.	Mill-Creek	WA 98012
Seattle Community College	Seattle	WA 98103
Northwest Alternatives, Inc.	Lynnwood	WA 98037
Olympic College	Bremerton	WA 98310-1699
Olympic Mental Health	Everett	WA 98203
Operation Improvement Foundation	Everett	WA 98201
Options	Lynnwood	WA 98037
Pacific Lutheran University	Tacoma	WA 98447
Pacific Oaks College Outreach	Bellevue	WA 98004
Pacific Treatment Alternatives	Everett	WA 98201
Peninsula College	Port Angeles	WA 98362
Phoenix Center	Arlington	WA 98223
Phoenix Center	Everett	WA 98201
Pierce College	Tacoma	WA 98498-1999

Site	City	State/Zip
Pine Lodge Corrections Center	Medical Lake	WA 99022
Planned Parenthood	Everett	WA 98206
Pre-Prosecution Diversion	Everett	WA 98201
Private Industry Council Sno. Cnty	Everett	WA 98204
Providence Recovery Program	Everett	WA 98206
Providence Sexual Assault Center	Everett	WA 98206
Recovery Services	Anacortes	WA 98221
S. Snohomish District Court	Lynnwood	WA 98036
Saint Martin's College	Lacey	WA 98503
Seattle Central Community College	Seattle	WA 98122
Seattle Pacific University	Seattle	WA 98119
Seattle University	Seattle	WA 98122
Sherwood Learning Center	Everett	WA 98208
Shoreline Community College	Seattle	WA 98133
Skagit Valley College	Mt. Vernon	WA 98273
Smith Wright Estates	Lynnwood	WA 98037
Sno. Center for Battered Women	Everett	WA 98203
Snohomish Co. Human Services Division.	Everett	WA 98201
Snohomish County Al. Detox Center	Everett	WA 98201
South Puget Sound Community C.	Olympia	WA 98502
South Seattle Community College	Seattle	WA 98106
Special Offender Center	Monroe	WA 98272
Spokane Community College	Spokane	WA 99207
Spokane Falls Community College	Spokane	WA 99204
TASC	Lynnwood	WA 98036
TASC	Everett	WA 98201
Tacoma Community College	Tacoma	WA 98465
The Center	Edmonds	WA 98020
The Evergreen State College	Olympia	WA 98505
Tulalip Tribal Alcoholism Program	Marysville	WA 98270
Twin Rivers Corrections Center	Monroe	WA 98272
U.S. Dept. of Education, Region X	Seattle	WA 98174-1099
University of Puget Sound	Tacoma	WA 98416

Site	City	State/Zip
University of Washington	Seattle	WA 98195
Valley General Alcoholism Treatment	Monroe	WA 98272
Valley General Outpatient Services	Everett	WA 98201
WA Corrections Center for Women	Gig Harbor	WA 98335
Walla Walla College	College Place	WA 99324
Walla Walla Community College	Walla Walla	WA 99362
Washington Corrections Center	Shelton	WA 98584
Washington State Penitentiary	Walla Walla	WA 99362
Washington State Reformatory	Monroe	WA 98272
Washington State University	Pullman	WA 99164
Western Washington University	Bellingham	WA 98225
Whatcom Community College	Bellingham	WA 98226
Whitman College	Walla Walla	WA 99362
Yakima Valley Community College	Yakima	WA 98907

Epilogue Part One:

Abuser

Sugar, I'll wait here.

No tellin' how long I'll wait.

'Cuz you're so sweet, the wait's been fleet; since you were born.

And you're so fine, the wait's devine.

Sugar, I'm right here; no tellin how long, dear.

Forlorn?

But you'll soon give, sure's I live, 'cuz i'm clear 'bout you.

Honey, drip on to me. No tellin' what can be.

For I'm fine, and you're divine; an' 'tween us both you'll see;

I'm you and you're' mine.

Lines ain't drawn that I can see: just us here that be.

Abileen and Grace; JoAnn and Funny Face. All mine; mine to 'xplore and

Probe. I'm first here.

That a problem? Oh my, oh dear.

I'll be damned.

But I think you'll sink into these advances, now or later.

No others risk the chances I will take for you: no boner, no mistake;

Just impropriety and penetrate, and more the less to hate.

Come Mommy and Daddy, your impotent clans,

All they done is wait–while such a one as I does plots and takes and Arrogates.

Confiscates; expropriates.

Disclose? Hymmphh, do try! Mine eye! I will not hesitate.

Destroy your virtue, future; days to come. To hell, expatriates!

Karen E. Redfield

Epilogue: Part Two

Salvation

Healing, balm and calm. Where art Thou? Where art Thee?
In this dark hour, of horror, shame, disgrace and utter obloquy?
I could learn, I want to know. I could be smart!
It smarts. But, hey now!
Is it I who parts from sanity and reason, to handle unscathed hearts?
Woe the light that finds my face.
Disgrace and Stain.
Yet, hold thou the chalice of my hope? Hold thou the hope of my returning?
My Yearnings, my Earnings?
Is there no accounting?
I hold out for meaning, endings, justice and designate; against wrong;
Unpropitious hate. Hale.
Patient, waiting, as was he, who abused and used;
And by other ways and other means.
Not for fame, nor pleasure, not dollars, nor acclaim.
But "for us," 'twas said.
Us, a tiny word of little truth. Seeking meaning.
Quest for heroes; quest for purpose; quest for reasons;
And Meaning, Purpose, Rationale, Why? Why? Why?
Hear Me and here am I. Here am I. Hear me.
Well, gone the truth of my chastity, brought to nothing.
But I was valid then, and I was trusting then. Do I need loving now?
Give me voice! I tell you, here am I!

Karen E. Redfield